

179734




Class _____ *No.* _____

Presented by

Gift.

Bdg. 2.60

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA



Digitized by the Internet Archive
in 2017 with funding from
The National Endowment for the Humanities and the Arcadia Fund

SOUTH DAKOTA

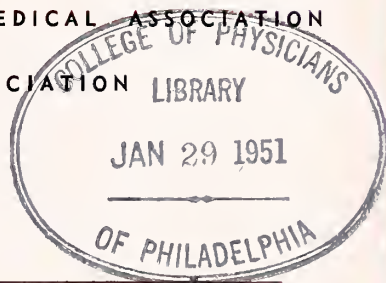


Journal

★ MEDICINE *and* PHARMACY ★

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION
AND
THE SOUTH DAKOTA PHARMACEUTICAL ASSOCIATION

JANUARY • 1951



REMEMBER THIS TERM?

Undoubtedly you would
if you had practiced in 1876,
when tinctures, buffalo robes, and elaborate mixtures
of prescription ingredients were in vogue—and Eli Lilly and Company
had just begun. Since then, the request to compound
a prescription *accuratissime*, meaning *most carefully*,
has become unnecessary. Today, progress has made pharmaceutical
accuracy certain. So you don't whip out
a quill pen and write *accuratis*.—when you specify Lilly.



Lilly

ELI LILLY AND COMPANY, INDIANAPOLIS 6, INDIANA, U.S.A.

*known
and
relied on
the world over*



ADRENALIN (epinephrine, Parke-Davis) is today, as it has been for many years, one of the most versatile and useful drugs, known and used the world over. Introduced to the medical profession by PARKE-DAVIS in 1901, ADRENALIN is widely used in many conditions — bronchial asthma, serum sickness, the Adams-Stokes syndrome, and anesthesia accidents.

PARKE, DAVIS

Treatment of Acute Allergy Met in General Practice*

Fred W. Wittich, M.D.
Minneapolis 2, Minnesota

In a brief presentation of a practical treatment of acute allergies met in general practice, it is obvious that a discussion of the integration of the complicated pathophysiology and disturbing emotional factors present in the individual patient is impossible. Claims to miraculous cures in allergy are developing so fast that controversial subjects are avoided and reserved for discussion. Undoubtedly, there are merits in a few of these claims, but "let us not be the first by whom the new is tried, nor yet the last to lay the old aside."

It is conservatively estimated that there are 150,000 people in the United States with major allergies, about one-third of them suffer from asthma. There are about 2,000 allergists qualified to treat them. It is obvious that the majority are seen for the first time by the man in general practice, or by the specialist not trained in the treatment of allergic states. Many seek relief for the first time when the disease is in an acute stage. In this paper, an effort will be made to offer practical suggestions in the management of the acute cases in the office and hospital. Since it is usually difficult to determine responsible agents, at the start physiologic therapy in the treatment of acute allergy assumes primary importance.

The most common of the distressing allergic diseases are the allergic dermatoses; urticaria, angioedema, atopic eczema, eczematous dermatitis of the contact type, and hay fever and asthma.

URTICARIA

Hives may be acute or chronic. About one-half of the population has been affected by the former at some time during their lives. They may be sporadic or frequent, and occur at regular or irregular intervals. The more serious type is the chronic urticaria. It has been known to last for months or years, and

may not respond to any form of therapy. They have even resulted in permanent disability.

The itching may be very distressing and wears the patient out from loss of sleep. No area of the body is immune from attack; they may be widely disseminated, but usually occur over pressure areas caused by clothing.

There appears to be some relationship between chronic urticaria and giant hives, or angioneurotic edema, preferably called angioedema. Giant hives, unlike ordinary urticaria, frequently affects the mucous membranes of the lips, mouth, throat, larynx and penis. Edema of the larynx may cause death, if not promptly treated. Patients who are sufferers from giant hives should have epinephrine within reach at all times, and should know how to administer it. The patient, nurse or physician should be prepared to give it at the very onset of the swelling of the larynx or of dyspnea. It may be necessary to perform a tracheotomy. It is a generally accepted opinion today that these urticarial swellings of the skin, especially giant hives, may be complicated by similar lesions in the viscera. It can be readily understood that when that does occur in the viscera, they may produce a variety of symptoms such as epileptiform seizures, Meniere's syndrome, migraine, which is frequently referred to as hives of the brain, papilledema, transitory blindness (retrobulbar optic neuritis), vomiting, gastric or colonic distress, attacks simulating gallbladder or kidney-stone colic or appendicitis.

Recently, an experienced Minneapolis surgeon, recognizing these possibilities, was about to operate on an eighteen-year-old girl for acute appendicitis. She had all of the symptoms, including vomiting and pain in the lower right quadrant, with tenderness on pressure. When she came to the operating room, he noticed she was covered with hives, and in consultation with an allergist, it was discovered that she had angioedema due to

* Read before the Sixty-Ninth Annual Meeting of the South Dakota State Medical Association, Huron, S. D., May 21-23, 1950.

the ingestion of eggs. The day before, at a cooking school, she prepared an angel food cake, using twelve eggs in it. She had liked it so well that she ate nearly all of it. Subsequent ingestion of eggs brought another attack, and withdrawal caused the symptoms to disappear. She has had no trouble on the elimination of eggs. When possible, a history may reveal the ingestion of urticariogenic substances such as fish, jelly fish, fruits, etc., exposure to plants, serum sickness or eruptions following the administration of biologic drugs such as vaccines, virus and skin tests.

It must be remembered also that patients may present itching wheals as a result of insect bites, scabies, pediculosis, nematode infection and dermatitis herpetiformis.

ACUTE URTICARIA

Every effort should be made to take a detailed history in an effort to reveal the cause, and eliminate, if possible, foods, drugs, environmental substances or physical agents (heat, cold, sun or ultraviolet light). Acute urticaria may also be provoked by nervous exhaustion, but this, more often, is a factor in chronic urticaria.

Very rarely does scratch or intradermal testing for wheal reacting reveal the cause. On rare occasions it may be useful when confirming suspected agents obtained from the history. It should be done only as a last resort, since it is of very little value. By far, the majority of skin tests, both direct and indirect (passive transfer) methods, are negative, since they represent the delayed type of reaction. If, on skin testing, there is an immediate type of reaction, the patient usually knows what the allergen is, so that the skin test may be a verification. Since the patient frequently recognizes an offending food, it is regularly avoided and only taken through error. In acute cases where a definitely known reacting food or drug has been taken, gastric lavage or an emetic may give quick relief. A purge with calomel, followed by a saline cathartic may also give early relief.

The local treatment for both the acute and chronic urticaria are similar, so that this will be mentioned in the treatment of chronic urticaria, as well as other procedures applicable to other acute allergies. The symptomatic treatment of urticaria consists of subcutaneous injections of epinephrine (1:

1000) 0.5 c.c., or epinephrine in oil 1.0 c.c., or ephedrine $\frac{3}{8}$ grain (0.024 gm.) by mouth, may be repeated from time to time as indicated. These measures temporarily relieve the pruritis and whealing. Most of the antihistamines give fairly prompt relief, and some of the more recently developed antihistamines have a more prolonged relief. The antihistamine is prescribed which the physician finds gives relief to the individual case with the least side reactions. It is found that if a patient reacts to one antihistamine with a certain chemical group, he reacts to the others with the same group, so that the physician now has a variety of groups to select from. The antihistamines which are dispensed in ointment form may also be tried locally. A barbiturate may be prescribed with ephedrine, but these occasionally cause exacerbation.

CHRONIC URTICARIA

Urticaria has a definite relationship to respiratory allergy, about one-third of the patients give a history of urticaria as an antecedent. In the treatment of chronic urticaria it is well to recognize that intrinsic allergies are chiefly responsible. Extrinsic factors should be considered, however, such as the constant use of drugs, like aspirin or barbiturates, cathartics or the daily eating of large quantities of some such allergic food as wheat, milk or eggs. Where intrinsic factors are paramount in the chronic urticaria, every effort should be made to locate any chronic infection in any part of the body, or any other concealed pathologic condition. Just as in other chronic diseases, faulty nutrition, endocrine imbalance, heredity, fatigue, biological, emotional, environmental and other factors play an important role. When extrinsic and intrinsic factors can be excluded, physical allergy may play a role.

When eradication of infective foci is not adequate through surgery, antogenous bacterial vaccines give very good results. Auto-genous culture vaccines (heat-killed) are given subcutaneously at five- to seven-day intervals until a tolerance dose is reached, when it is given at a ten- to fourteen-day interval for about ten additional doses, and then carried on a perennial, two weeks to one month, interval as indicated. The relief of itching and affording rest is paramount. Bromides, in 15 grain doses orally may be administered for a period of time, but the pa-

tient may become easily sensitized to bromide. Chloral hydrate, 10 grains by mouth or chloral hydrate and a bromide by rectum may be used. The barbiturates should be given with caution, since they may aggravate the condition. In very acute cases where the suffering is intense, sedation as in acute asthma, may be given when two to three drams, or more up to one ounce, or paraldehyde is administered, with warm water as a retention enema at twelve hour intervals. This is injected high by means of a catheter and a closed syringe which produces excellent sedation without side effects. Attacks at night are best relieved by epinephrine in oil 1 c.c. by the intramuscular route, orally, or ephedrine $\frac{3}{8}$ grains (0.024 gm.) in enteric coated tablets. Colloidal baths at bedtime help to relieve. Instructions for a colloidal tub bath: to 8 tablespoonfuls of soluble starch, add a little cold water and stir to make a paste. Add 6 tablespoonfuls of baking soda. Over this pour one quart of boiling water. This must be added slowly because of the effervescence. Stir vigorously. Add this mixture to one-third of a tub of warm water and mix. Antipruritic lotions of one to three per cent phenol in calamine may give a relief to some of the itching. The intravenous administration of Calcibronat. (Sandoz), 10 c.c. or 1.24 gm. in ampule form should be administered daily or every other day. Another excellent antipruritic in prurigo, eczema and urticaria, which is also a sedative and an analgesic, is Ekzebrol (Tosse). The contents of a c.c. ampule containing 10 per cent strontium bromide, after being warmed to about body temperature, is injected slowly, intravenously, daily or every other day.

Intravenous and subcutaneous administration of histamine have given successful results in chronic or recurrent urticaria, angioedema, allergic reactions to insulin, when patients show allergic symptoms when exposed to cold temperatures, serum or drug sickness, certain types of allergic headaches, Meniere's syndrome and other allergies of the central nervous system. It is specific for histaminic cephalagia.

In urticaria and angioedema, as in other cases of histamine sensitivity and primary vasodilatation, the intravenous injection of histamine is recommended. One cubic centimeter capsule containing 2.75 mg. of his-

tamine diphosphate is administered in 250 c.c. of isotonic saline solution by the gravity method. The rate of flow is adjusted so that 2 to 8 c.c. enter the vein every minute, requiring a minimum of one and a half hours for injection of this amount of solution. The rate of flow is adjusted to prevent flushing or headache. Sometimes two or three treatments are given on successive days. Patients receiving histamine intravenously should be given food just before, during, or following the injection.

Intravenous desensitization with histamine may be followed by increasing doses of histamine, given subcutaneously every five days until the tolerance dose is reached, after which this dosage is maintained at five day to seven day intervals for an indefinite period. A convenient unit is the Venopak, a completely disposable venoclysis unit, the content of which is sterile and ready for use with 250 c.c. of isotonic sodium chloride in triple distilled artesian water in a special container. When endocrine dysfunction complicates the picture, suitable glandular therapy is indicated in conjunction with histamine. Increasing subcutaneous doses of histamine may then be used until the hives disappear.

Satisfactory results with subcutaneous histamine therapy depends upon its administration at short intervals, daily or twice daily. Commence with 1:10,000 dilution giving 0.05 c.c. twice daily the first two days, and 0.10 c.c. the third and fourth day, followed by eight injections daily, commencing with 0.15 and increasing 0.05 c.c. with each dose. This is followed by a 1:10,000 dilution of six doses every two days with a 0.05 c.c. increase, when a maintenance dose of 0.30 c.c. is injected every third day. As the larger doses in this series are reached, systemic reactions do not necessarily indicate a reduction in the dose, as they are usually momentary.

Urticaria due to light has been shown to be greatly benefited by Pyribenzamine, which apparently increases a tolerance to light on an average of sixfold.

If the patient is in the hospital, an intramuscular, or preferably intravenous injection, of Benadryl, Neo-antergan, Histadyl or one of the antihistamines tolerated by the individual patient, sometimes gives very satisfactory results. Benadryl, or Neo-antergan, for injectable purposes comes in 10 c.c.

"sterivials," 10 mg. per c.c. An effective dose ranges from one to five c.c., depending upon the patient and the condition treated. It is injected very slowly and stopped immediately upon a complaint of nausea, vomiting or other symptoms of side effects.

If reactions to the antihistaminic drugs are unfavorable, 10 c.c. of a ten per cent solution of calcium gluconate or calcium thiosulfate may be given slowly intravenously. A subcutaneous injection of an anticholinergic drug such as 0.43 mg. (1/150 grain) of atropine sulfate (racenic hyascyamine) is at times helpful. This includes scopolamine (levohyoscine—Hoffman-LaRoche) or the mixed belladonna adkaloids (Bellafoline-Sandoz) in terms of levohyoscine.

Menadione (synthetic Vitamin K) in doses of 2 mg. three times daily for from one to four weeks was reported by Black to relieve 62 per cent of a large series of cases of urticaria and angioedema, who failed to respond to other forms of treatment. The speaker has found Vitamin K very helpful in a large proportion of the cases, particularly those in the younger age group, and does not hesitate to give double the dosage mentioned, particularly where the prothrombin time was prolonged.

Where the patients sleep is greatly disturbed, hypnotics may be used where they do not appear to be contra-indicated by the history such as phenobarbital (0.015 to 0.030 gm., or $\frac{1}{4}$ to $\frac{1}{2}$ grain, or Bellergal, one tablet three times daily. Occasionally excellent results may be obtained with Gynergen, 1 mg. tablet, two or three times a day.

Chronic nervous exhaustion is a frequent cause of persistent urticaria, if conditions are explained to the patient and if he has an insight into his condition, he can be helped frequently by a change in environment and forgetting his worries.

ECZEMA

By far the majority of eczematous lesions are allergic in nature.

Atopic or neurodermatitis is a member of the urticarial group, and the initial lesion is an edema in the cutis. Scratching and trauma cause vesiculation and itching of the folds of the elbows and knees, and on the face, wrists and outer aspects of the lower limbs, although particularly in infants, the lesions may be disseminated and involve most of the body

surface. Relief of itching reduces the dermatitis greatly aggravated by scratching.

Treatment is much more satisfactory when the specific allergen can be determined by the usual diagnostic methods of skin testing, avoidance and re-exposure. Foods are primary contributing factors in early life and frequently in adults, so that prescribed diets based on the patients clinical sensitiveness are important. It is not uncommon to find that infants and young children are sensitive to house dust and its various components, so that the usual avoidance measures should be carried out. Immunization measures also, particularly with the inhalant factors in conjunction with a prescribed diet, are essential.

Symptomatic therapy consists of use of the antihistaminic agents as described in the treatment of urticaria. They have been nearly as useful as in urticaria. This also holds true of calcium therapy. Other non-specific measures are bacterial vaccines, or the use of staphylococcus toxoid. Hansel reports favorable results in the treatment of atopic eczema and the dermatitis of penicillin sensitivity following the use of extremely low doses (2 units) of straphylococcus toxoid. The mechanism is hypothetical and is supposed to be due to microshocks. Vitamin injections, especially Vitamin B, frequently are used.

LOCAL TREATMENT OF ACUTE LESIONS. Hot or cold wet dressings are one of the most useful forms of local treatment. Closed dressings are preferred for ambulatory or less acute cases. Open dressings are better when the skin is acutely inflamed, infected, or there is itching. Do not use absorbent cotton or gauze packs, but make compresses from old unstarched sheeting folded six to eight ply and cut to fit the area.

Fresh milk packs may be used in an emergency. A physiologic or slightly hypertonic saline solution may be used. Burow's solution (Liquor aluminii acetatis) 1:20 is commonly preferred, which may be prepared with Domeboro Tablets Improved (Dome Chemicals, Inc.). These tablets contain lead-free aluminum subacetate. One tablet should be dissolved in 8 to 16 ounces of water, preferably distilled. If Burow's solution is not well tolerated, 3 per cent saturated boric acid solution may give relief. When treating an infant, care must be taken not to cover too much skin surface with boric acid solution,

as death may follow from boric acid poisoning. When there are infected areas and there is some odor, a freshly prepared solution of potassium permanganate, commencing with 1:10,000 in water and increasing in strength as tolerated, is an excellent solution for wet packs. Darier's solution, which consists of copper sulfate 1 gram, zinc sulfate 2 grams, and camphor water to make 120 c.c., may be tried also. Three teaspoonfuls added to one pint of distilled water is used as a wet pack. Other wet applications used are a silver nitrate solution, 0.25 to 1 per cent, or a solution of sulfureted calcium, 1:10 or 1:30, or sulfureted potassium, 1 teaspoonful in from 1 quart to 1 gallon of distilled water.

An acute dermatitis of the hands, feet, scrotum, anus or buttocks can be treated by soaking the part in a basin containing one of the various solutions mentioned. When the patient likes and tolerates solutions, the wet packs are not interrupted. However, some patients feel more comfortable when the wet dressing is removed for one-half to one hour and then reapplied. A thick, greasy ointment or paste should not be used in the interim because it prevents the aqueous solution, when reapplied, from reaching the skin properly. Compresses may be replaced by an oily lotion, such as Ichthyol or Tumenol, 2.5 grams; boric acid, 3.6 grams; zinc oxide, 48.0 grams; and olive or corn oil to make 120 c.c. This is applied twice daily with an applicator and the parts bandaged. If this is too drying, it may be alternated with an application of Burow's ointment.

Sometimes itching can be relieved considerably by frequent changing of hot, plain water packs. If the acuteness subsides, a modified Rosen's ointment can be applied as a bland salve, consisting of:

Modified Rosen's ointment—

Burow's solution	20.0 c.c.
Aquaphor	20.0 gm.
Cetyl-Stearic Base of Upsher-Smith	20.0 gm.
Zinc paste (Lassar's)	40.0 gm.
Crude coal tar may be added after the acute inflammation subsides	0.5 gm.

or "one-two-three" Burow's ointment to which 0.25 per cent menthol and 0.5 per cent phenol, or 2 per cent Liq. carbonis detergens, have been added.

Bland, oily ointments should follow the

packs, never stimulating ointments containing tar, as the lesions subside very satisfactorily. A good ointment is:

	gm. or c.c.
Benzocaine	3.0
Naftalan	1.0
Zinc paste	45.0
Petrolatum q.s.	60.0

Since Benzocaine may be a sensitizer, 0.5 per cent phenol and 0.25 per cent menthol may be substituted.

In neurodermatitis of adults a tenacious and strongly antipruritic ointment is chlorbutanol, 10 per cent and zinc oxide, 25 per cent, in lanolin.

Chloresium, a water-soluble chlorophyll, is a hydrophilic ointment also used for itchy dermatitis.

An emulsion for tender areas which is useful as a soap substitute or detergent when cleansing eczematous areas is sodium benzoate 0.1 gram; glycerin 10.0 grams; cetyl alcohol 20.0 grams; sodium lauryl sulfate 1.0 gram; and water 64.0 grams. Other soap substitutes such as Lowila and pH isoderm may be used also. Soaping thoroughly and washing carefully until the soapy water is completely removed by repeated rinsing is done better by a warm spray followed by a cooler spray. Cleansing with mineral oil or olive oil may sometimes be necessary.

INFANTILE ECZEMA

There are certain features of atopic eczema in children which require special mention. Mothers who breast-feed eczematous babies should omit eggs, avoid wheat, especially cereals as much as possible, avoid foods which commonly cause gastrointestinal distress or urticaria, and reduce their amount of milk consumption or drink goat's milk, since allergy to milk may be transmitted by the mother to the child. The omission of milk requires extra calcium in the diet. The eczematous infant should be fed every four to five hours throughout twenty-four hours, and usually at a single breast. This schedule prevents rapid gain in weight which is undesirable.

The same schedule of feeding should be followed for artificially fed infants. If there is no relief of symptoms following an evaporated milk formula, change to evaporated goat's milk, powdered goat's milk, plain goat's milk, Nutramigen, or one of the soy bean

preparations. Gastrointestinal distress from the use of these products may be overcome by adding one to two teaspoonfuls of Kaopectate or Pectocel to each feeding.

Eliminate eggs and egg products from the start, and other foods on the basis of previous experience with common offenders or by skin tests. It is best also to eliminate wheat, tomato, chocolate and oranges. Supplementary vitamin C should then be used along with other vitamins such as Vi-penda drops or Vi Magna granules or syrup.

Sulfonated oils without tar may be tried in the bath. Strict avoidance of contact with the various components of house dust must be observed. No pets are allowed.

It may be necessary to restrain the child by placing cuffs on the wrists and ankles and tying cuffs to the bars of the crib with strips of cloth. Trauma to the face is prevented by having the child sleep on an anti-frost shield fastened to the pillow. Sedation by any of the elixirs of the barbiturates is helpful, as well as chloral hydrate 1 to 2 grams by mouth or 5 to 10 grains by rectum.

In cases of acute eczema of the contact type patch testing should not be done until the acute condition has subsided, and then only by one familiar with its technic and inherent dangers. Medication for the contact type is quite similar to that of treating atopic dermatitis. Plant oil injections have been favorable in some cases. An excellent antipruritic lotion in contact dermatitis is Histadyl and Surfacaine containing in each c.c.:

Histadyl	2 gm.
Surfacaine	0.5 gm.
Calamine	8.0 gm.
Zinc oxide	8.0 gm.

HAY FEVER

Approximately 75 per cent of patients sensitive to pollens are also sensitive to certain foods, particularly during the hay fever season, and these should be eliminated at that time. A patient with seasonal pollinosis, therefore, should be tested for sensitivity to known common offenders in the diet.

Stock treatment mixtures containing pollen antigens in proper proportion for various sections of the country are now furnished by various companies which produce biologics. A special treatment mixture may be made consisting of the proper proportion of only

those pollens to which the patient reacted by the various methods of testing.

Directions for preseasonal, perennial and primary co-seasonal specific therapy of hay fever and asthma are contained in the numerous books on allergy and will not be described here with the exception of that of the more recent method of combining antihistamine therapy with specific pollen immunization. Maietta reported unusually good results in pollinosis with combined antigenantihistamine therapy and thus shortening the treatment of hay fever. His pre-seasonal schedule consists of eight rapidly increasing doses of pollen antigens to those over 100 pounds of 250, 500, 1,250, 3,000, 6,000, 10,000, 15,000 and 20,000 Coca-Noon Pollen Units; while the patients under 100 pounds received half this dosage. The treatment was started anytime and given monthly, bi-weekly, weekly or semi-weekly, but timed so that the last injection just receded the pollen season. Co-seasonal treatment consisted of the same number of injections but received according to their weight, one half of the pre-seasonal dose. The perennial schedule extends from one season to the beginning of the next and given for a couple of years. Top pollen doses were injected at bi-monthly intervals, beginning with the month following the season, and ending with the sixth dose just before the season starts. With these six bi-monthly injections yearly, the need of subsequent preseasonal or co-seasonal therapy is unnecessary.

Various antihistaminic drugs were used orally in conjunction with specific immunization. Individual doses of the drugs were large or about two and one half times the recommended amounts.

Prophylactic doses were given in such a manner that their effect would last twenty-four hours. A preliminary pre-injection double dose was given twenty minutes prior to each injection of pollen, and one hour after the patient received a double dose of antihistamine. This was followed by a single dose every four or five hours, for four doses.

In Maietta's series, 60 per cent developed side reactions, but were relatively mild and never enough to prevent continuance of the drug.

The writer, for the past two hay fever seasons, has given a single dose of any antihis-

tamine tolerated by the patient, a half hour before the larger doses of pollen antigen. As the hay fever season approached, there were no systemic reactions and results were excellent.

When a patient consults the clinician just as the hay fever season starts, whether due to grass or ragweed pollen, he is started with daily subcutaneous injections of 0.1 c.c. of a 1:5000 dilution by weight of a combined grass or combined weed mixture taking a tolerated antihistamine two or three times daily. If this dosage gives relief, injections are continued without increase for two or three days and then given at intervals of two or three days, and later placed on a twice weekly schedule. If 0.1 c.c. does not give adequate relief after twenty-four hours, the dose is increased to 0.2 c.c. If relief follows with this dose, continue with the same dose as outlined above.

If this dose does not relieve, increase to 0.3 c.c. If relief follows, continue as given above, otherwise increase to 0.4 c.c., but never go beyond this dosage with the combined use of an antihistamine.

It has been found that when antihistamine therapy is combined with immunization measures, it is unlikely that asthma will develop. Excellent results have been obtained by this simple procedure and the patient may obtain satisfactory clinical relief without a prolonged preseasonal or perennial series of injections.

Instead of an antihistamine, 0.3 c.c. of epinephrine 1:1000 or a mixture of equal parts of epinephrine, 1:1000 and 3 per cent aqueous ephedrine administered with the pollen extract gives immediate relief. Ephedrine sulfate injectable can be obtained in ampules containing $\frac{3}{8}$ gr. or $\frac{3}{4}$ gr. to the c.c. It is also available in tablet form for hypodermic use in $\frac{1}{2}$ grain (Lilly).

ASTHMA

TREATMENT. The most annoying form of respiratory allergy which disturbs the general practitioner or the chest specialist is bronchial asthma, particularly in the acute form or status asthmaticus. When this is present, symptoms are treated first, and following relief the investigation of causative factors is commenced, whether inhalants, ingestants, including drugs of any kind, injectants and contactants. The patient usually is very ap-

prehensive and should be reassured that patients rarely die of an acute attack of asthma. Status asthmaticus is considered to exist when all the usual orthodox forms of therapy have failed. Unlike chronic intractable asthma, it is an acute condition which is usually reversible.

The older the patient with bronchial asthma, the greater the chance of both extrinsic or intrinsic infective factors being present. In the chronic infective type, the use of antibiotics sometimes are startlingly beneficial. Aerosolization may be used with the antibiotics alone or preferably combined with concentrated epinephrine or Isuprel, with the flow meter set between 4 and 5 liters per minute on the oxygen tank when oxygen is used as a conveyor. Higher pressures with the proper nebulizer such as the DeVilbiss No. 40 may also be used. Foot and hand pumps generating compressed air are now available and less expensive. In any event the nebulized particles should be so fine as to be practically invisible. The patient should be told to breathe in gently and not forcibly, with the mouth wide open, while the nebulization is taking place, and to hold the breath if possible momentarily and not to exhale forcibly. By this method, the finer particles penetrate the lower respiratory tract. Ten per cent glycerin added to the aerosolization mixture helps to stabilize the particles. For an aerosol solution, the author obtains very satisfactory results with a combination of daily inhalations, from five to seven days in succession, of 25,000 to 50,000 units of crystalline penicillin in isotonic saline solution to which has been added 0.1 c.c. of concentrated epinephrine, Isuprel, an isopropyl derivative or Aleudrine hydrochloride (570 mg.) and 0.1 c.c. of glycerite of peroxide. Instead of penicillin, a combination of streptomycin and tyrothricin (1:2000 dilution) has not produced any toxic reaction. Bacitracin has also been employed. Also for aerosol therapy other remedies such as a 5 per cent solution of sodium sulfathiazole may be used.

In the treatment of status asthmaticus, sedation and hydration or supportive therapy are paramount. Protecting drugs in the management of bronchospasms, therapeutic use of gases, bronchiolar evacuation, or "catharsis," and the management of infection should follow. For sedation, paraldehyde, by

rectum, does not cause the irritation produced by ether in olive oil. Also 100 mg. subcutaneously, of Demerol, to be used only in acute cases of asthma, may be very helpful. Hydration consists of an intravenous injection by the slow drip method of a liter of 5 per cent (isotonic) dextrose, or in some cases, 500 c.c of 10 per cent dextrose in distilled water. Dextrose in greater concentrations up to 50 per cent has repeatedly been advocated. It is more desirable to use 5 per cent dextrose which is isotonic, and furnishes both water and calories. This solution should also contain $3\frac{3}{4}$ grains (10 c.c. ampule) of aminophyllin and 0.5 to 1.0 c.c. of 1:1000 solution of epinephrine and should be given at the rate of 60 to 80 drops per minute. Distilled water is preferred to isotonic sodium chloride solution since there has been ample evidence furnished that sodium chloride will make asthma worse. This mixture may again be administered in six to eight hours if necessary. One should not follow dextrose with insulin. Some form of vitamin B complex and vitamin C may be given in the saline or dextrose solution or intramuscularly, especially in those patients who are very weak from inability to take proper nourishment. If necessary to maintain nutrition, blood plasma or a blood transfusion of 250 to 500 c.c. may be necessary. Oxygen or preferably oxygen and helium may be administered by means of a tent or mask or nasal catheter. A dry, irritating, non-productive cough may be treated by a carbon-dioxide (5 per cent), oxygen, with or without helium, mixture. Positive pressure tents advocated by Barach, have certain advantages.

In the treatment of bronchial asthma of the less acute type, each patient presents an individual problem. There is no treatment that is always best nor any that must be used first. The management of these patients depends upon a careful examination and continued observation of the patient. A thorough general examination should be made of all the domains of the body when determining influencing factors. When possible, there should be a change of environment, preferably to a hospital and in an allergen-free room. Allergic cleanliness — when treating a patient at home every measure should be taken to make the room as allergen free as possible by using allergen-proof bedding or

encasings. Any articles which may collect dust, such as drapes and rugs should be eliminated. There is now on the market a preparation known as "Dust-Seal" which when applied to specific surfaces (floors and primarily fabrics, such as carpets and upholstered furniture and blankets) imprisons or seals the particular matter known to allergists as house dusts, preventing their dissemination and contamination of the air. The dust particles are immobilized by this procedure, and the preparation is harmless to fabrics.

For immediate relief the sympathomimetic amines, epinephrine or ephedrine, or a combination of epinephrine and ephedrine, as well as the various epinephrine-like (synthetic) group such as ephedronin, neosynephrine, propadrine, Orthoxine and Isuprel or Aleudrine are used. In this group also is included tyramine and amphetamine (benzedrine sulfate). The group of xanthines which have a local action on smooth muscle without nerve transmission and which are very beneficial in a large number of cases are theophylline-ethylenediamine (aminophyllin); theophyllin (theocine); theobromine, and theocalcin. These xanthines are frequently combined with one of the sympathomimetic amines and one of the barbiturates in capsule or tablet form. Where the secretions are scanty, potassium iodide or potassium iodide in combination with apomorphine makes a very effective expectorant as well as a cough sedative. Aminophyllin is best given in concentrated form when treating the acute asthmatic. As a rule, $3\frac{3}{4}$ grains is first given to determine the patient's toleration; $7\frac{1}{2}$ grains may then be used. These come prepared in 10 and 20 c.c. ampules and should be administered slowly intravenously. Precautions should be taken in administering aminophyllin to patients who may have coronary disease. A feeling of warmth or flushing in the face is an indication to administer more slowly. Aminophyllin may also be given in suppository form. This form is particularly useful when continuing the effect of the aminophyllin. The use of aminophyllin will often relieve the epinephrine "fast" state. Monotheamin (Lilly) administered orally, intramuscularly, or intravenously (from 1 to 7.5 grains) injected slowly gives good results in some cases.

As pointed out by Davison, a mixture of

epinephrine hydrochloride, 0.5 to 0.8 c.c. with Demerol 50 to 100 mg. and apomorphine hydrochloride, grains 1/120-1/100-1/80-1/60, mixed together in the same syringe and given one-third every ten to fifteen minutes until all is given or until relief is obtained, maybe very efficacious.

In relieving nervousness or apprehension when the patient is not sensitive to the barbiturates, injections of sodium phenobarbital are preferable. This drug should be administered in doses of 2 to 5 grains, as often as necessary, if the patient is sensitive to barbiturates, chloral hydrate, chloretone or bromides may be used in appropriate doses orally or by rectum.

In the treatment of acute asthmatics, bronchoscopy has been very effective in a number of cases. By means of this method the removal of mucous plugs may be life saving. Endoscopic instillation with bactericidal or bacteriostatic acting agents including penicillin, sulfanilamides and streptomycin. Intrabronchial instillation of iodine in oils may likewise be used as an effective medium. The iodine in the oils is relatively inert and has little or no antiseptic value. However, by mixing with the pocketed secretions, the instillations mechanically keep the patient in cleansing the larger and medium sized tuber. Instillations of 250,000 units of penicillin or 500 mg. of streptomycin in 20 c.c. of Pantopaque (depending upon the organisms present in one of the iodine preparations (Pantopaque) may be of tremendous supplemental value to penicillin aerosol therapy — may mix with 1 c.c. of 1 per cent Neosynephrine and 0.20 c.c. of Vaporephrine or Isuprel 1:200 in 10 to 20 c.c. of Pantopaque. Penicillin and/or Sodium Sulfathiazole, 5 per cent in normal saline may be used for bronchial lavage.

Recently a case was reported by Shapiro, et.al., at Chicago of an unusually severe case of intractable asthma in an eighteen-year-old girl, who did not respond to any of the usual procedures for treating status asthmaticus and whose condition was desperate. Oral administration of procaine hydrochloride resulted in a miraculous recovery. She had only one attack since which was promptly relieved by the oral administration of procaine hydrochloride. She has gained 35 pounds and remains well as long as she takes 25 grains on arising and half that amount on retiring.

When treating some of the complications of acute or prolonged bronchial asthma particularly where there are signs of heart failure, 5 grains of citrated caffeine may be given orally, or caffeine sodium benzoate, grains 7½, by hypodermic injection, may be tried, or Coramine, 5 c.c. intramuscularly or intravenously as a cardio-respiratory stimulant. Digitalis is used for impending right or left sided cardiac failure, and the dose should be enough to digitalize. It may be necessary to use the Levine tube through the nose to relieve gastric distention. Intestinal distention may be relieved by the use of a salt and soda enema and rectal tube. Pituitrin in small doses may also be given. Some patients respond well to the use of a saline laxative or particularly to a half to one teaspoonful by mouth or heavy magnesium oxide.

ALLERGY HEADACHES

One of the most common symptoms of allergy of the central nervous system is the allergy headache. An allergy headache may be persistent or periodic with vomiting (migraine). True allergy headaches can be proved to be due to hypersensitiveness, but cannot properly be called migraine because the cerebral cortical symptoms are absent. Allergy usually is manifested in both the family and personal history of these patients. The allergens usually are foods, but occasionally inhalants. It is suggested that allergy headaches are possibly produced by edema of the brain not unlike angioedema of the skin. Migraine attacks have been attributed to vasomotor changes of the meningeal vessels, especially those branches of the external carotid artery. Therapy consists of treatment of the underlying hypersensitiveness by avoidance measures, or if necessary immunization with inhalants if they are responsible. Symptomatic measures consist of the administration of epinephrine or ephedrine. The migraine or paroxysmal headache associated with visual symptoms and gastrointestinal phenomena may or may not be due to an allergy. The so-called histamine headaches (histaminic cephalalgia) are not considered by Horton as a migraine. The pathogenesis of migraine is still controversial. Symptomatic relief frequently is obtained by subcutaneous injections of ergotamine tartrate (Gynergen) 0.5 to 1.0 c.c. (0.25 to 0.5 mg.). It is less effective when given orally in tablet or liquid

form. Dihydroergotamine is also used. Cafergone (Sandoz—lmg. ergotamine tartrate and 100 mg. caffeine) has been reported by Horton, Hansel and others as superior to ergotamine tartrate alone for these types of headaches. The coal tar derivatives are less effective. Endocrine therapy, including Pituitrin, has been used. Saline cathartics, gastric lavage, avoidance of fatigue and emotional upset, cold or hot applications, narcotics and oxygen by inhalation have all been used in giving relief. Nonspecific therapy with autogenous vaccines has been used, as well as digestive aids such as bile salts and pancreatic enzymes. Patients have been known to obtain relief from the removal of foci of infection, while others suffer so severely that sympathetic ganglionectomy has been performed. It is important when instituting general measures for these patients that nervous factors, adequate rest, diet and vitamin intake be controlled. Glandular extracts may also be used. Histamine intravenously occasionally may give spectacular relief just as in histamine cephalagia.

COLLATERAL REFERENCES

- Vaughan, W. T.: Practice of Allergy, ed. 2, rev. by J. H. Black, St. Louis, C. V. Mosby Co. 1948.
- Stoesser, A. V.: The Care of the Infant and Young Child with Eczema: Graduate Instruction Course in Allergy, The American College of Allergists, College of Medicine, University of Cincinnati, Nov., 1947.
- Horton, B. T. MacLean, A. R., and Craig, W. M.: New Syndrome of Vascular Headache: Results of Treatment with Histamine: Preliminary report, Proc. Staff Meet., Mayo Clinic, 14:257 (April 26) 1939.
- Hansel, F. K.: The Treatment of Headach, with particular reference to the use of Cafergone (ergotamine tartrate and caffeine) for the relief of Attacks, Ann. Allergy, 7:155 (March-April) 1949.
- Abramson, H. A.: Principles and practice of aerosol therapy of the lungs and bronchi. Ann. Allergy, 4:440, 1946.
- Mothersill, M. H.: Treatment of hay fever with a combination of a sympathomimetic and an antihistaminic drug. Ann. Allergy 8:223, 1950.
- Miller, J.: The parenteral use of Neo-Antergan, Ann. Allergy 8:68, 1950.
- Maietta, A. L.: Unusually good results in pollinosis with combined antigenantihistamine therapy. Ann. Allergy, 7:789, 1949.

CUFF NOTES

Fractures in Infants and Children

Diagnostic pointer: An abnormal swelling along an extremity in an infant or child may be an unrecognized fracture, or one which occurred due to unadmitted negligence on the part of the parents, or during a rapid delivery to save an infants life.

Deformity in the infant and very young child is compatible with good functional result. Any weight bearing bone must have length restored, especially the femur. R. L. Gorrell, Clarion, Iowa; Clinical Medicine, July, 1950.

Transfusions for Anemia

Infections, rheumatoid arthritis, rheumatic fever, cause an iron deficiency anemia that does not respond to iron. Administered iron is stored in the tissues, which are already oversaturated, but it is not absorbed. If the anemia is severe, the only effective therapy is that of transfusions of blood, and of course, that directed at control of the original infection. C. A. French, Harvard Med. School, American Practitioner.

Heart Symptoms with Goiter

Thyrotoxicosis should not be diagnosed unless tachycardia, auricular fibrillation or other fault of the pulse or heart is found. The discrepancy between sleeping and waking pulse rate is not as great as in nervous tachycardia. Digitalis is without much effect on this rate. Wm. Evans Proc. Royal Soc. of Med. Eng., May 1949.

Increasing Dysmenorrhea

Increasing pain with menstruation is typical of endometriosis. Pain on movement of the cervix by vaginal examination, jarring, coitus, defecation, or sitting down suddenly is significant. John Fallon, M.D.

The greatest danger to any physician is that he may become a little person in a little world.

Nothing is more important to American medicine than the preservation of individual initiative and freedom of thought and action.

When
Your Patients
Ask You About

**HOSPITAL
INSURANCE**

REMEMBER

LEE McCAHREN
314-16 Paulton Bldg.
Sioux Falls, So. Dak.

ALL
PAUL REVERE
POLICIES ARE

**NON-CANCELLABLE
GUARANTEED RENEWABLE**

Primary Carcinoma of the Lung*

C. S. Larson, M.D., Sioux Falls

This talk on primary carcinoma of the lung will necessarily be a summary of the important aspects of the problem. In addition, I will present several illustrative cases showing the difficulty associated with handling of these patients having carcinoma of the lung.

The first total pneumonectomy was done by Rudolph Nissen in Germany in 1931. The first total pneumonectomy for carcinoma performed in one stage was done in April, 1933, by Evarts Graham. Since then, thoracic surgery has become almost as commonplace as abdominal surgery.

The incidence of primary carcinoma of the lung is approximately 7% of all admissions for primary malignant neoplasms. It is not rare, and there is a gradual but progressive increase in the incidence of carcinoma of the lung. It is more frequent than carcinoma of the stomach. About three-fourths of all primary lesions occur in males and slightly more than half in the right lung. 90% occur in the fourth to seventh decades although it may occur in any age group.

As a rule, it is a very rapidly progressing disease, and subsequent to diagnosis, about 85% die within eighteen months.

The primary early symptoms are cough and vague thoracic discomfort or pain. Productive cough, hemoptysis and wheezing may occur rather early. Dyspnea, severe pain, hoarseness and debility are as a rule late manifestations. The most frequent symptom that brings the patient to the doctor is usually hemoptysis. The symptoms are present less than six months in almost half of the cases that are treated. Approximately 2% of patients without pulmonary symptoms can be expected to have primary carcinoma of the lung.

The diagnosis is frequently difficult. First of all, THERE MUST BE AN AWARENESS OF THE LESION. In any patient with prolonged chest pain, cough, dyspnea, or hemop-

tysis, bronchogenic carcinoma must be suspected and a thorough search made, especially if the patient is a male over forty years of age. Because of the rapid progress of this disease, the slightest clinical suspicion should be followed immediately by other diagnostic measures. The diagnosis of carcinoma of the lung may demand the use of numerous methods: various roentgenogram exposures; bronchoscopy with examination of the bronchial secretions obtained at bronchoscopy; biopsy of the lesion; examination of the pleural fluid for malignant cells; aspiration biopsy, which is not generally recommended; exploratory thoracotomy; and a therapeutic trial by x-ray. The therapeutic trial by x-ray is of some value in differentiating a highly radio-sensitive lymphoma, providing the definitive treatment is delayed not more than four weeks following irradiation if the lesion fails to show marked reduction in size.

The roentgenogram is probably the most valuable single method of obtaining an early presumptive diagnosis of bronchogenic carcinoma. The x-ray is positive in from 75% to 82%. Bronchoscopy is positive in 40% to 75% when it is feasible to do bronchoscopy. Cytological examination of the bronchial secretions is positive in almost 90% of cases when it can be obtained. Aspiration biopsy, which is not generally used but might be used when surgery is contraindicated, is positive in a much smaller percentage. Exploratory thoracotomy is indicated in any patient in whom clinical symptoms raise suspicion of bronchogenic carcinoma even though other diagnostic procedures have not yielded positive findings. The mortality from exploratory thoracotomy is practically zero.

The pitfalls in the diagnosis of primary carcinoma of the lung include: (1) confusion with a benign tumor, which can be avoided by exploratory thoracotomy where other methods fail, (2) pulmonary abscess, also avoided by exploratory thoracotomy which should be done in all cases of chronic cavitating disease of the lung in an adult for which

* Presented at the Clinical Program, Sioux Valley Hospital, Sioux Falls, South Dakota, April 25, 1950.

some specific etiological factor cannot be found, and, (3) pneumonia, which can be avoided by followup roentgenograms and by maintenance of a high degree of suspicion for any lesion which does not disappear roentgenologically in two to four weeks.

The treatment of primary carcinoma of the lung is surgical. In recent years, the surgical extirpation of the involved lobe or preferably the entire lung is the only satisfactory method of treatment in good operative risks. The resectability rate varies from about 4% to 25%. Following pneumonectomy, approximately one-fourth of the patients survive five years if the lesion is resectable. Roentgen ray therapy is of some value for palliation in patients not suitable for surgery either because of the extent of the lesion or because they are a poor operative risk. Craver reports 3.8% five year survival rate in this method of treatment.¹ At times there is marked palliation to thoracic metastases and prolonged survival. Recently, there has been reported a method using Dicumerol to maintain the prothrombin level between 10% and 30% of normal and giving a tumor-sterilizing dose by x-ray to carcinoma of the lung and esophagus without apparent parenchymal changes in the lung. This is a preliminary report, however, and has not been used extensively. Nitrogen mustard has been used but has a considerably less palliative effect than has the use of x-ray. Palliative pulmonary resection is occasionally used but is of little value.

¹Quoted by Ariel, et al.

Case 1: A sixty-two year old white male complained of dyspnea in March, 1948, with onset of productive cough in September, 1948. A film on March 28, 1949 reveals an enlarged heart with right pleural effusion (figure 1a.) In June, 1949, he had hemoptysis followed by chills and associated with dyspnea. He was treated in the hospital for pneumonitis. The film at this time indicates an increase in the fluid on the right (figure 1b.) Re-examination on December 10, 1949, following thoracentesis, reveals a decrease in the fluid and also a mass at the right base with enlarged right hilar nodes. Bronchoscopy with biopsy in December, 1949, disclosed a bronchogenic carcinoma of the right lung, squamous cell types, and the patient died within a few weeks without further treatment. This case illustrates the

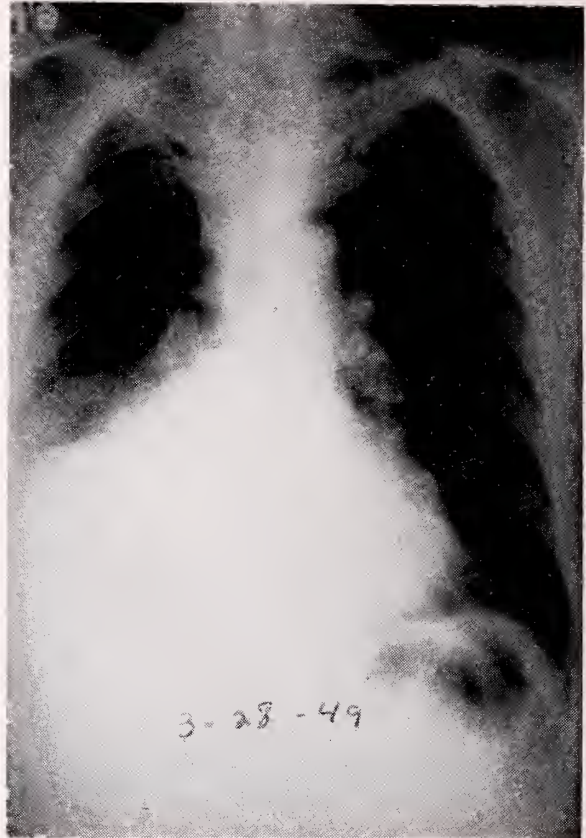


Figure 1-A

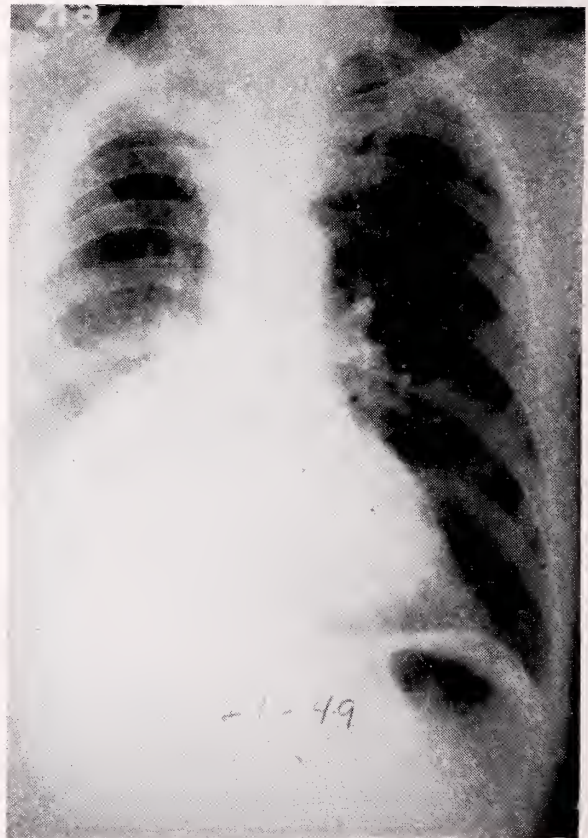


Figure 1-B

necessity of early investigation of pulmonary symptoms and follow-up of demonstrated pathological lesions to establish the diagnosis of a malignancy at an operable stage. If the diagnosis had been made at the onset of the original complaint of dyspnea and productive cough, operability would have been much more likely.

Case 2: A forty-year old white male complained of weight loss but no cough and had a low-grade fever and elevated sedimentation rate in January, 1948. The film reveals slight haziness over the left apex but was considered to be negative (figure 2a.) In March, 1948, the patient was thoroughly examined at a large clinic where the diagnosis of tuberculosis was made. As the patient was preparing to leave for his home, he was recalled and told that the sputa obtained at bronchoscopy revealed malignant cells; all other findings were normal. A left pneumonectomy was performed and the pathological report was bronchogenic carcinoma, large cell type. In September, 1948, the patient developed anorexia, weakness and loss of weight. The film reveals the post-operative left chest

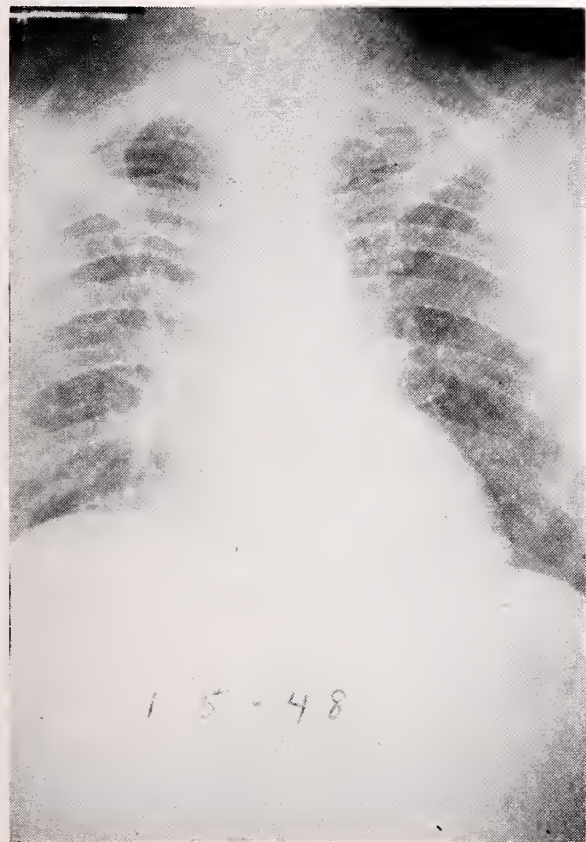


Figure 2-A

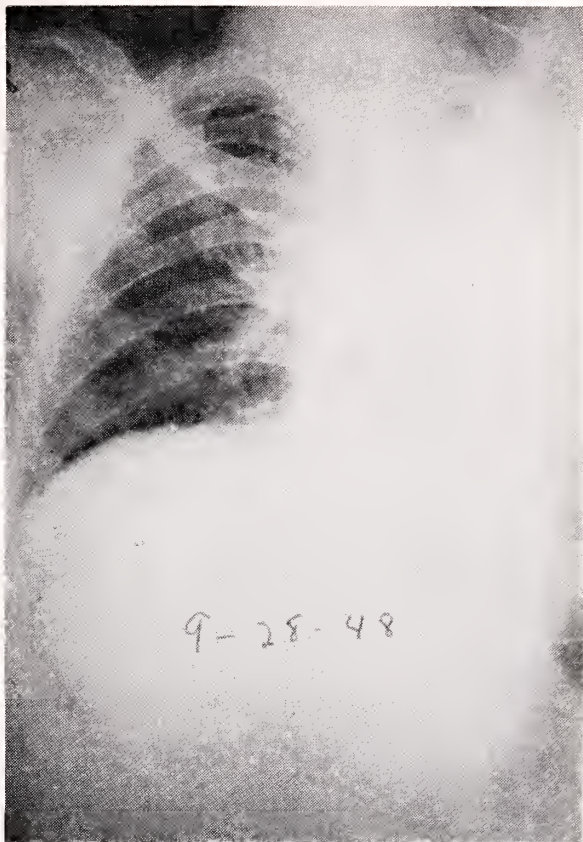


Figure 2-B

filled with fluid (figure 2b.) He expired in October, 1948, with metastases to the right kidney and liver. This case illustrates the difficulty sometimes associated with establishing a diagnosis and also the necessity of thorough investigation of suspicious pulmonary findings found by x-ray.

Case 3: A fifty-eight year old white male developed a cough in March, 1949, which soon became productive. He had had some pain in the chest and dyspnea for six months previous to the cough. The film on March 25, 1949, indicates probable malignancy with metastases (figure 3a.) Re-examination on August 3, 1949, reveals progression of the lesion (figure 3b.) The patient took a rapid downhill course and expired on September 20, 1949, with bronchogenic carcinoma, undifferentiated cell type, with metastases to the thorax. This case illustrates the sometimes very rapid progression of the disease and the need for thorough investigation immediately at the onset of symptoms.

Case 4: A fifty-three year old white male complained of fever, malaise, aches and pains in November, 1946. These symptoms im-

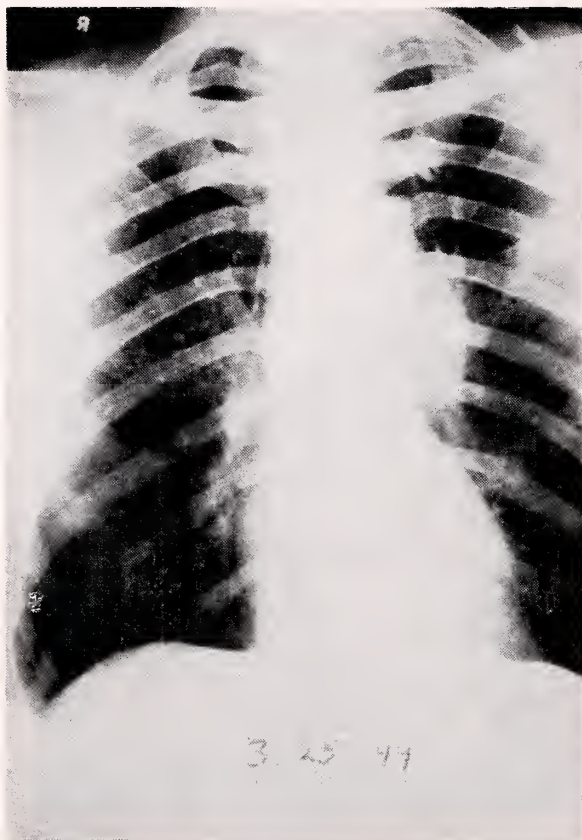


Figure 3-A

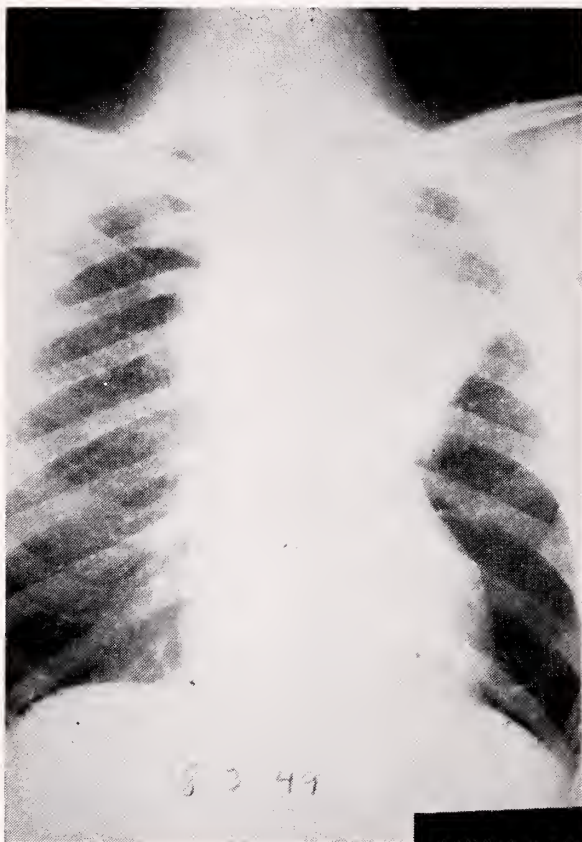


Figure 3-B

proved on sulfathiazole and penicillin. The film on November 20, 1946, reveals right pneumonitis with associated fluid (figure 4a.) The fever recurred and a dry cough and pain in the right chest developed. Re-examination shows some decrease in the fluid on the film of November 23, 1946, (figure 4b.) In May, 1947, he developed pain across the chest and back. In July, 1947, he developed hemoptysis and the film again shows the persistent density (figure 4c.) Bronchoscopy was done which demonstrated a tumor. A right pneumonectomy was performed and the diagnosis



Figure 4-A

was made of small cell type adenocarcinoma. He was given two x-ray treatments to the chest in September, 1947, without effect and expired in October, 1947, probably with local metastases. This case illustrates the importance of follow-up of lung infections which are frequently associated with lung tumors.

Case 5: A sixty-two year old white female in December, 1948, developed a cold following which symptoms persisted with intermittent productive cough, no hemoptysis. In March, 1949, she developed a pleuritic pain in the left chest. By July, 1949, she had lost

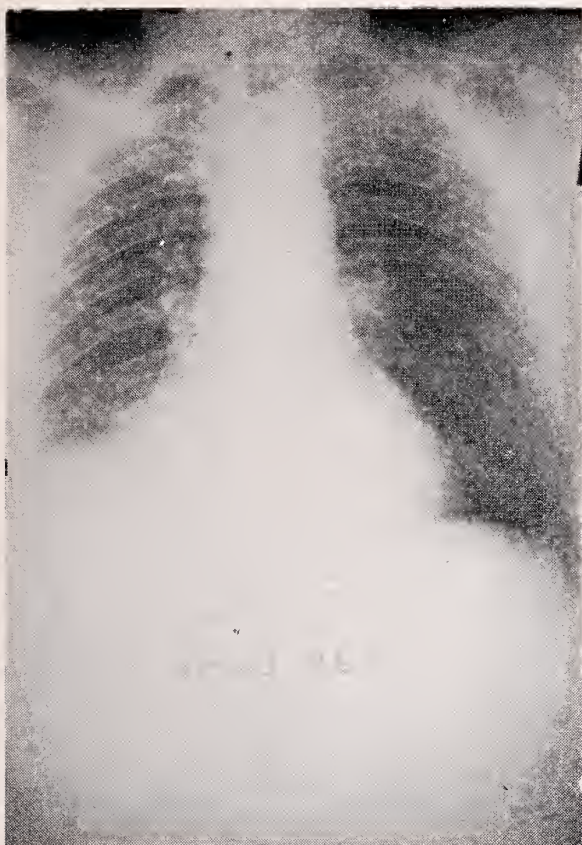


Figure 4-B

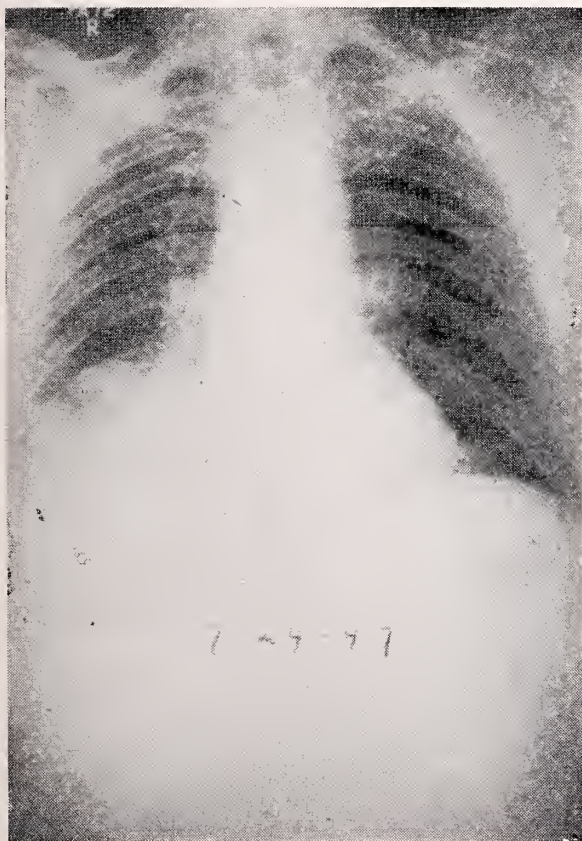


Figure 4-C

twenty pounds in weight and a cholecystectomy was done for gall stones. The film of the chest reveals a mass at the left base (figure 5a.) Several days later, she developed dyspnea and the chest pain became progressively worse. The film on August 2, 1949, demonstrates an increase in the mass (figure 5b.) The pleural fluid revealed malignant cells. The left chest was explored and the lesion found inoperable, as was suspected by finding cells in the pleural fluid. The diagnosis was adenocarcinoma of the left lung by biopsy. X-ray treatment from August 15,

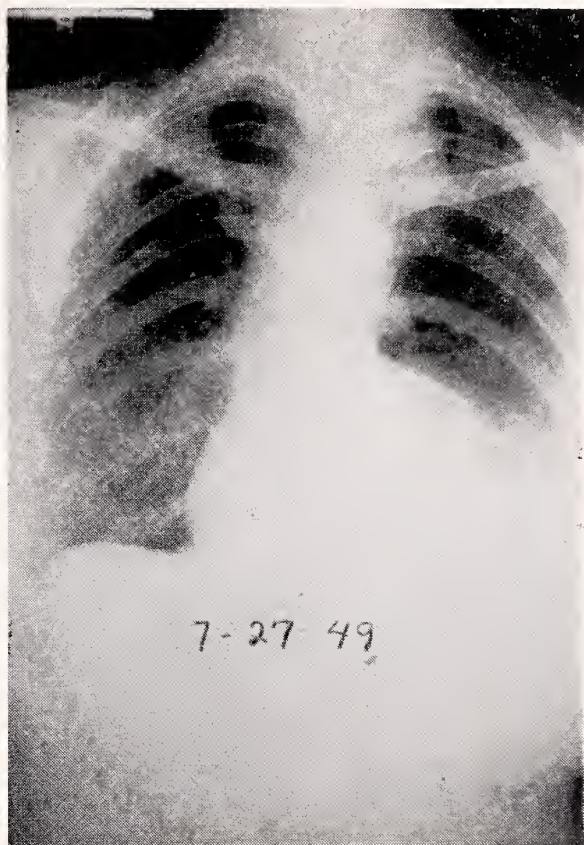


Figure 5-A

1949, to September 8, 1949, produced some palliation. The film of October 11, 1949, reveals the status after treatment (figure 5c.) This case proves the fallacy of ignoring chest symptoms in the presence of other obvious pathological conditions. Thorough investigation is mandatory.

Case 6: A thirty-two year old white female on March, 1948, received a report of the chest taken by the mobile unit: "area of increased density in the hilar region of the left side that is well-circumscribed." The film of April 9, 1948, reveals the lesion; a diagnosis



Figure 5-B

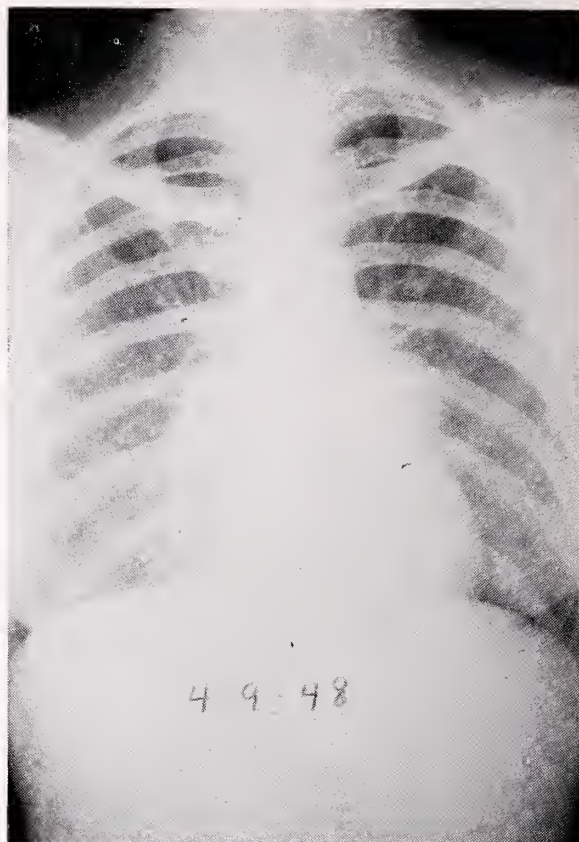


Figure 6-A

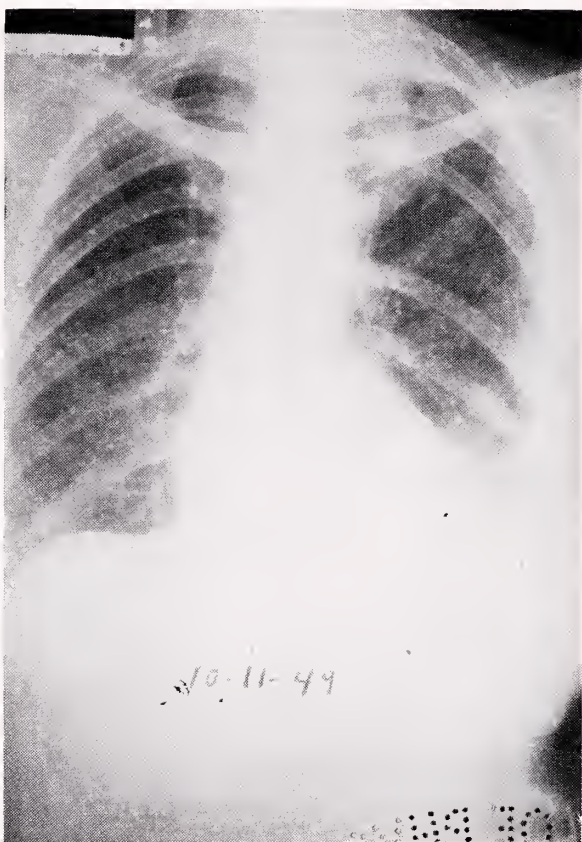


Figure 5-C

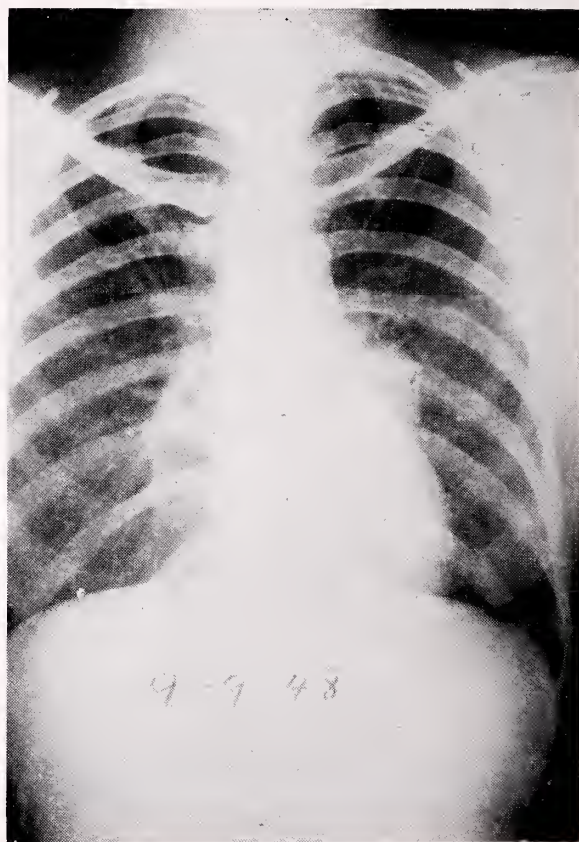


Figure 6-B

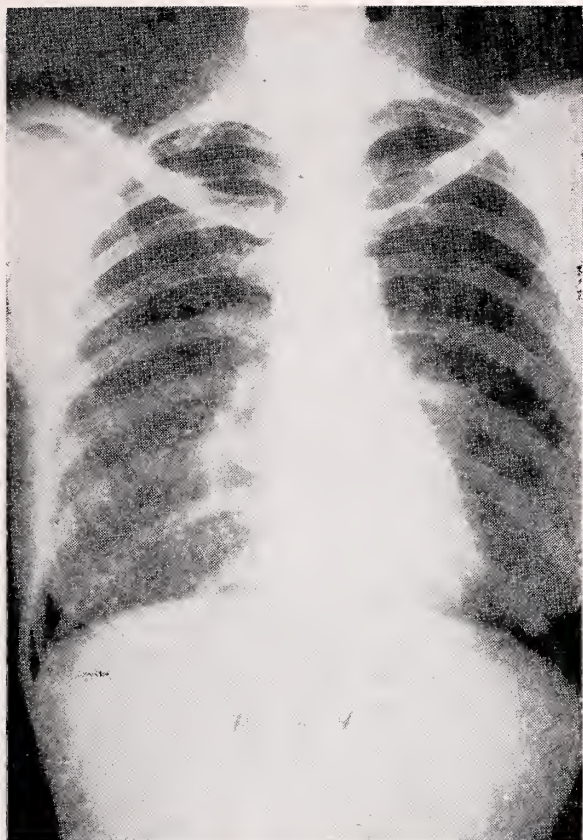


Figure 6-C

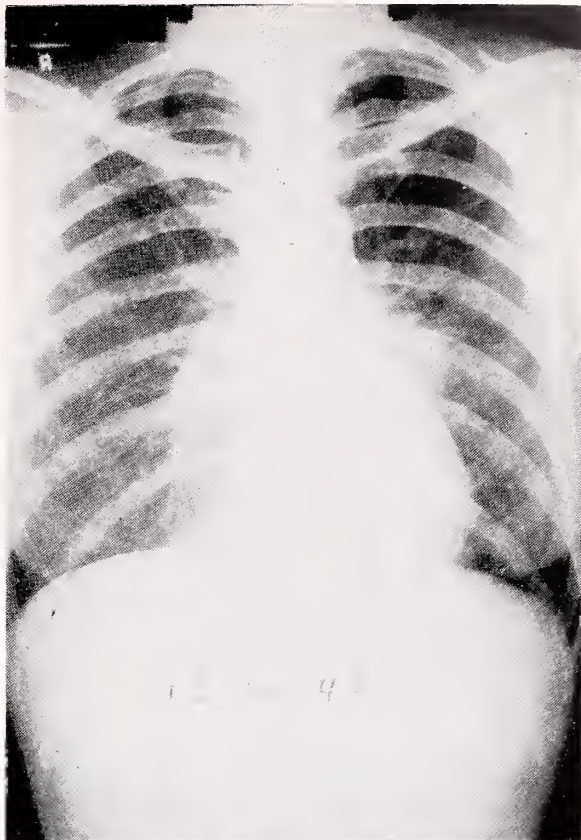


Figure 6-E

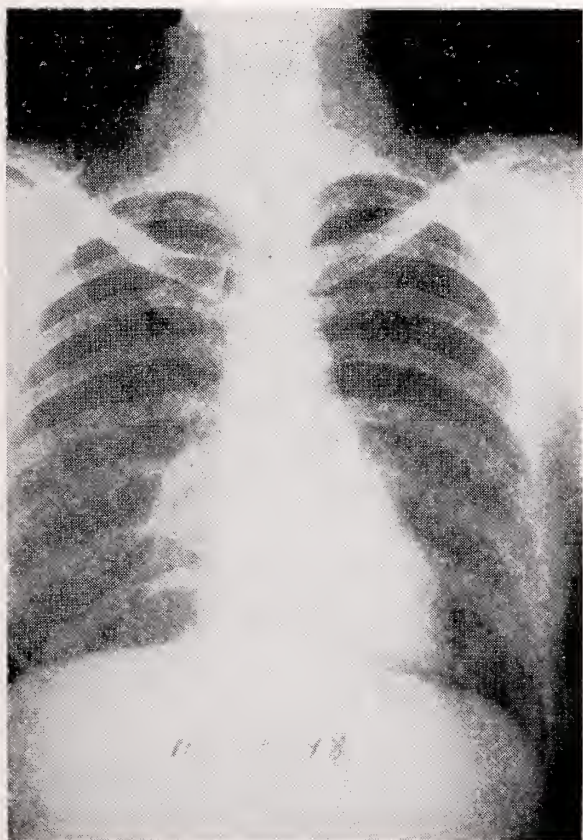


Figure 6-D

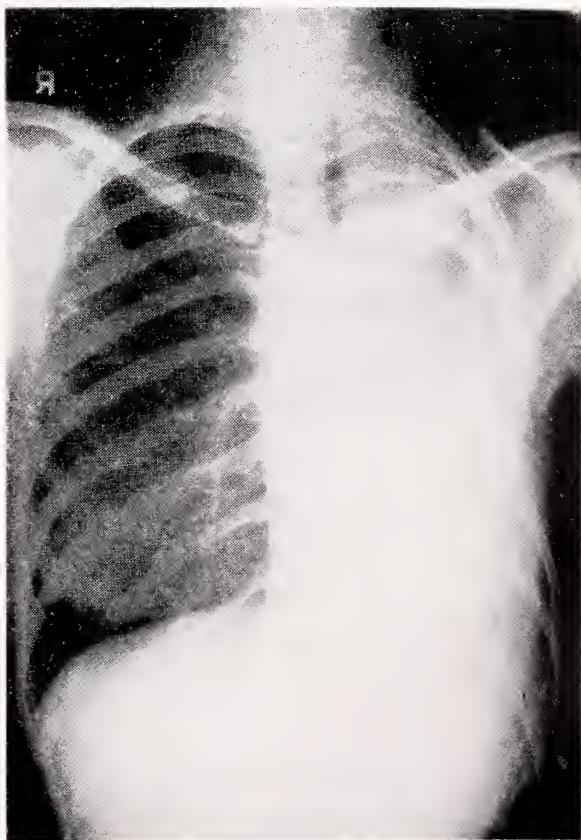


Figure 6-F
(Continued on Page 38)

Hospital Service vs. Medical Practice*

L. J. Pankow, M.D., President SDSMA

In its zeal for furthering the welfare of the patient, medicine has consistently fostered ideas and sponsored developments that have grown into independent professions and associations. Sometimes these secondary professions and associations possess ideologies not to the best interest of the parent organization.

Doctors had long depended on the housewife, the religious order and the "handy" neighbor-woman to help with the patient. When Florence Nightengale conceived the idea of organized nursing the profession helped liberally to develop the present highly regarded nursing profession.

Likewise it was discovered that if patients could be brought together in one place, with the help of nursing, much more could be done for many more patients, by each doctor. Although not originated by doctors, the hospital idea developed and improved by them, until we have the Hospital as we know it today, and the mighty American Hospital Association.

So too, was developed the idea of special training requirements and definite qualifications instead of self-satisfying and unsubstantiated declaration of specialization. Specialty boards were approved to certify specialists in various fields of medicine.

Even the corner drug store became an American Institution because the medical profession found it was better for his patient to have standardized medicines prepared by someone who devoted his full time to that work, than for the individual doctor to concoct and formulate his own syrups, elixirs and pills. Thus developed the modern pharmacy and the pharmaceutical laboratories and factories.

Let us be charitable, tho, and not refer to these and other similar developments from the medical profession, as Frankenstein Monsters, but rather as caudal appendages that have grown and grown until now, at times,

the tail wags the dog. — The nursing profession no longer seems to care much what doctors may believe a nurse should be or what she should be capable of doing; it now tells US what a nurse will do and know, and most definitely it tells us what she will NOT do. — No longer does the doctor go into his drug cabinet and mix up a physic for Grandpa. He doesn't even write out a formula of what he wants in the medicine that he prescribes. He recalls that the detail man for a well known drug house told him about a new compound, so he writes the name of the medicine on his prescription blank and so, often his prescription becomes only a requisition on the druggist for so many ounces of this or that out of a supply bottle, or such a number of pills out of a supply bin, any and all of them being better prepared than he or the druggist of old could have done. — The specialist is no longer just one of us whom we call when we have an especially difficult case or need a special skill. In general, THE SPECIALIST, (in capital letters, too, if you please) belongs to a genus that admits its superiority over the general practitioner, and intimates that the best job for a general practitioner is to refer his patients to the proper specialists, if indeed, he is even necessary for that.

Any one of these problems deserves great and careful deliberation. Physicians do not disapprove nor decry the progress that they have assisted in producing in these fields nor in any other progress that is for the good of the patients. None would care to return to a medical practice without these developments, aids and helps, even tho they have grown completely out of the hands of the profession that created them or very materially helped in their development.

Now we have the maturation of the Hospital. The hospital used to be a place where the Doctor took his sick patient to obtain, with the help of diagnosis and conveniences of nursing care, the best for his patient, and where he could treat that patient as he per-

Presented at the North Central Medical Conference Minneapolis, Minn. Nov. 19, 1950.

sonally believed he should. Now it becomes a member in a Hospital Association and if the doctor is a good little boy, he may bring in his patients IF he conforms to all the rules and regulations set up by the association and practices a standardized sort of medicine of which they approve. In September of 1950, the House of Delegates of the American Hospital Association, despite definitely expressed disapproval by the American Medical Association, passed this resolution, from which I have deleted some words but none of the meaning whatever: "Resolved, that the American Hospital Association establish a hospital standardization program . . . in the development of standards relating to the practice of Medicine in hospitals . . .". I ask, what can this be but an attempt to dictate to the medical profession HOW it may treat its patients, and that the doctor must conform his treatment to a standardization set up by the hospital association?

These, Gentlemen, are some of the problems that we must face as well as take care of sick people. Little by little the "Rights, honors, and privileges" conferred on us by our Medical Diplomas and confirmed by our State Boards, are being chipped away from us. Chipping small pieces from the original to change its shape or form is also known as chisseling, and even as gouging. Chipping, chisseling and gouging is getting commonplace. They not only chip at the practice of medicine but they bicker and gouge at each other with no very great care, if any, for the parent organization, medicine, or the welfare of the public whatever. Nurses go out on strike; technicians quit their jobs in a huff; pharmacists object to doctors or hospitals maintaining drug rooms and dispensing their own medicines and supplies; Hospitals exploit their trainees in nursing and their graduates. Hospitals are even practicing medicine in competition with the members of their own staffs. What else can it be when hospitals employ persons to practice anesthesiology, pathology, laboratory diagnosis, and radiology or roentgenology, with exclusive practice rights in the hospital? No doubt there are other medical specialties being taken over by hospitals, but these are enough to start with.

There are many facets to this situation. Every encroachment now effective was un-

doubtedly originally suggested by the doctors themselves for improving service that could be given to patients. It is good that the hospitals have a crew of competent anesthetists who know the newer techniques and modalities. It is also good to have a competent pathologist who can direct the laboratory and diagnose tissues and fluids from patients. It is also good to have available x-ray facilities and competent directors for this work, and men to read films and direct treatment for doctors who have not the time, money or equipment to do this work for himself. So, today it is common to find in every good general hospital, especially in the larger centers, specialists in these fields, in the employ of the hospital either direct by salary or on a percentage basis with a minimum guarantee. The hospital charges the patient for these services and pays for the specialists an agreed wage or percentage, and retains the balance for its own profit. This constitutes definite competition by the hospital practicing medicine, against other doctors in the community that are competent or desire to be doing this work. It can hardly be called competition, because it is actually a monopoly. If an anesthesia is given, laboratory work done, or x-rays taken, the fees charged for the work includes pay for the specialist in that department, and if the service of the specialist in interpreting the technical work is not needed or desired by the doctor, that makes no difference, the patient pays for it anyhow. If the opinion of a specialist in the field, other than that provided by the hospital is used, the patient must arrange to pay for that over and above the hospital fee already charged. The hospital employed specialists thus enjoy an exclusive guaranteed practice, with, in most instances, the hospital doing all the collection of their fees.

These are the FACTS as they exist. The questions that arise from them are up to the medical profession to answer if we can. The questions are: 1. Where does hospital service end and medical practice begin? 2. What will be the logical conclusion of the trend? and 3. What shall we do about it?

1. Where does hospital service end and the practice of medicine begin? It would seem rather obvious that the same sort of reasoning that delineates between testimony and expert testimony in courts of law could well

apply here, and that when technical service alone is not enough, and one must rely on judgment, opinion, and skill in a specialty, that would be as good as any place to draw the line. The insurance companies in their hospital benefit policies pretty generally include the whole service of the tissue preparation and the interpretation as laboratory service, and the reading and interpretation of x-ray films as well as the technique of obtaining the films, as x-ray service, and as such they pay for this work. The same applies to anesthesia, for they do not differentiate between the furnishing of the materials and equipment for anesthesia and the judgment and opinion of the specialist in that field when he determines what anesthetic agent to use or how much. The great increase in popularity of hospital insurance and the great number of persons now covered by these benefits thus would seem to uphold the general feeling that these special medical fields are in fact hospital services. This then introduces still another angle. Patients when advised to have complete laboratory and x-ray studies performed, naturally want to take advantage of their insurance policy benefits, and so insist on entering a hospital for their diagnostic work. The hospitals are not adverse to this because they have hired specialists in these fields, and the more work done in these departments and paid for, the better they can pay the specialists so hired, and the greater the profit to the hospital not only from the room used by the patient, but from the profit on each specialty examination rendered by their hired specialist. The insurance companies are paying for diagnostic work and for bed space for a patient during diagnosis and for diagnosis only, and not for hospital confinement for sickness alone, as intended. This forces insurance rates to go up above what should normally be, for the hospital thus collects for bed care on a patient not necessarily ill enough to be hospitalized, and also for diagnostic work that is a medical service and could well have been done in the doctor's office. Thus the income of the hospital is increased at the expense of the doctor who could do the diagnostic work in his office, but who would not get paid for it by the Insurance company. One cannot blame the hospital for increasing their income. One cannot blame the patient for getting the

service paid for by a willing insurance company, and the average doctor will not argue the matter with the patient even tho he loses his income from that source, at the risk of losing his patient's good will. The specialty professional association are telling their members to remember that they are physicians and should personally charge each patient for work that they do on them. These Associations advocate that the specialist should rent the space and equipment he uses, and bill the patients direct for the professional service rendered. Hospitals rather uniformly will have none of this. In effect they say, "Here is the office and equipment and the technical help to run the department. We want you to supervise and direct the technical work. We will pay the expenses of the department, supplies, help and all the rest of it; you just see that the department functions and get out your opinion reports, that is, tissue diagnoses and x-ray interpretations. We shall pay you a salary for your work, or a commission percentage of the work done. We must, however, make enough money from this department to pay you and the expenses of the department, and a goodly profit besides, so it does not make a great deal of difference whether you accept a wage or a commission. In any event it must be clearly understood that you are working with us. In return for this humiliation of being a hireling we will give you exclusive rights to practice your specialty in this hospital. You will make your cut on every patient that comes into the hospital and has work done in this department. Even if a doctor does not value your opinion or judgement nor desire your service, you will get your pay from his patient anyhow. Even if another specialist is called in to check the technical work on a patient, that will be at the patients additional expense, and your pay will come just the same. You have exclusive practice rights and a monopoly on all work done in this hospital in your department."

Financially, the specialist in these departments, does all right for himself. This exclusive practice privilege idea pays off. The hospital of which I am chief of staff for this year recently acquired a new pathologist. This is his first job aside from his army service, and he impresses us at being the best of the applicants we had and interviewed. We are paying him more than a thousand dollars

a month, tho, and a percentage of the gross of the department. Besides that he not only can, but is encouraged to solicit outside referral work, of which the hospital gets a percentage for the technical part of the service. The Specialty Associations don't like their members to work on this basis, as I have said. The hospitals are pretty stubborn about it tho, because they realize that they are making a nice profit from these departments and they don't want to lose it. The doctors in these departments would like to run their own business and professional work, but since the hospitals won't play that way they have to accept. I don't know how you men look at this, but to me, when services are forced onto a patient that could have been and maybe were done in his doctors office just the afternoon before, and here are repeated and charged for by the hospital, that is practicing medicine by the Hospital.

2. What will be the logical conclusion of the trend? The trend is obvious. If hospitals manage to continue with these profitable arrangements, why not add more and more medical services? Why not, as is being done in some places, add obstetrical or psychiatric departments? Why not other packages of medical care such as tonsillectomies, appendectomies, and so on. Where will it necessarily stop? Under coop plans hospitals in some areas are in fact furnishing complete medical and surgical care. These are logical and possible conclusions. Altho few in number, they do exist, and what might ultimately come is anyone's guess.

3. What can or should be done about it? This is the real problem, and frankly, I doubt that anyone has the answer at this time. Perhaps it will all work out by trial and error, proposal and counterproposal, and by what the public demands for which it is willing to pay. The hospitals are not going to give up willingly a system that gives them a nice net profit. Doctors certainly are not willing to give up the availability of these specialties in their hospitals, and would in fact be lost without them. I believe tho, that a more ethical and satisfactory arrangement could be worked out than we are enjoying at this time. I believe that there should be a sharp delineation between technical services and professional opinion and advices. I believe that hospitals should maintain good and ef-

ficient departments in the various diagnostic and clinical aids specialties, and that they should employ competent specialists to direct them and to operate them at a reasonable profit to the hospital. I believe that these specialists should be available for consultation and medical advices when requested by the doctor in charge of a patient in the hospital. I do not believe that every patient should of necessity be forced to buy that specialists opinion. I believe that any pathologist or roentgenologist should have equal privileges in a general open staff hospital, and that exclusive practice rights should cease. I believe that the attending doctor should have the right to determine when and if he desires the skills of the specialist employed by the hospital, or of some other similar specialist, or of none at all. After all, he may be as competent in some fields as the specialist himself. I believe that insurance companies should change their policies so as not to furnish medical care by the hospital under the guise of a hospital service, and thus divert from doctor's pockets money that is rightfully theirs.

Gentlemen, my conclusions:

1. The medical profession has allowed many subsidiary professions and associations to assume such proportions that they have become, not only independent, but at times, arrogant.

2. There is definitely an attempt by the American Hospital Association to dictate to our profession as to how he may practice medicine in their hospitals.

3. The granting of exclusive practice privileges to hospital employed specialists and denying these privileges to other well qualified specialists in unwise, unjust, and unethical discrimination.

4. When a hospital makes a profit from an employed physicians medical services to patients, that hospital is practicing medicine in the guise of hospital service.

5. There is no guarantee that hospitals will not employ doctors in other specialties to operate other departments, rendering medical services to patients in the name of hospital services, at a profit to the hospitals and at the expense of other doctors in the community. I refer particularly to obstetrics and surgery.

(Continued on Page 38)

Mid-Century White House Conference on Children and Youth

by S. D. State Medical Association Delegate, John C. Foster

Meeting of Medical Representatives at Mid-Century White House Conference, December 3, District of Columbia Medical Society Auditorium.

Meeting opened with a discussion by Dr. Crawford who discussed the history of the various White House conferences with particular emphasis on the nineteen recommendations of the 1930 conference which are known as the "Childrens Charter."

Dr. H. F. Helmholtz, chief consultant of the White House Conference, discussed the planning and aims of the 1950 conference. He discussed the three types of sessions; the general sessions, panels, and the work groups.

Dr. Donald Dukelow of the American Medical Association's Bureau of Health Education spoke on his part of the fact-finding work done prior to the conference.

Group broke up for discussions and then placed their questions before the assembly. Most queries were on organization of the work groups.

The meeting concluded at 1:45 p. m.

Meeting of South Dakota Delegation, Sunday, December 3, Dodge Hotel, 5:00 p. m.

Meeting presided over by Mrs. C. F. Schmidt which was attended by thirty of the delegates.

Discussion held on continuation of the Governor's Committee.

Two resolutions were suggested to the group. 1. Seek legislative sanction to be a permanent committee with some appropriation for operation. 2. Suggest a series of local meetings be held for public discussion.

Discussion centered on functions of such a committee plus organization. Dr. Weller moved continuance of Governor's Committee. Seconded by Foster — carried.

Roney moved legislative sanction of such a committee. Seconded by Freeman—carried.

F. Dunn moved expenses be allowed advisory committee members. Seconded by Weller — carried. Freeman moved appro-

priation for office expense. Seconded by Roney — carried.

Discussion held on what should be done on return from meeting.

Suggest aggregate report on — work groups recommendations, personal opinion, and how they can be implemented at home.

First General Session

The first general session was opened by Oscar Ewing, Federal Security Administrator, who introduced Rev. George Butterick, of the Madison Avenue Presbyterian Church of New York who keynoted the conference speaking on "Spiritual Foundations for our Work with Children and Youth."

Oscar Ewing spoke on the plans and aims of the conference.

Monday Morning, December 4 — General Session.

Melvin Glasser, executive director of the conference outlined plans and aims of the conference.

Dr. Benjamin Spack of Rochester and Leonard Mayo gave talks on our knowledge of youth and how to put it to work.

Panel Discussions.

Groups broke up into 15 panel discussions on various subjects.

Workshop #13 December 4, 2:30 p. m. Attended by the writer.

This was discussion of influences on employed youth. General discussion of church, school and family guidance and instituting a consciousness of the importance of work.

Discussed — Readiness for work, vocational training, counseling, desirable working conditions, farm labor.

Second Meeting — December 5, 1950.

Recommendations

1. To work at 16 youth should have — education, health, good working conditions. Amendment offered to except "dire national emergency," carried.

2. Suggested basic age 14 outside school

hours and on vacations. Amended with a preamble. Carried.

3. Motion to include a report in principle on recommendations of responsibility of labor and industry, etc., to develop early work of such type the child's personality develops properly. Carried.

4. Maximum 8 hours day — 40 hours week — no night work — rest periods — for minors under 18 lunch.

5. Hazardous occupation protection.

6. Limitations of combined hours when youth works and goes to school. (Through high school) carried.

7. Employees should hire youth in spite of future call to service. After much discussion of findings as brought in by recorder, motion made to table and specifically turn to questions of working conditions and experiences as related to personality development of employed youth.

Following Recommendations passed by group to submit to Conference.

It is generally recognized that work for young people who are old enough and for whom the employment is suitable, is a valuable and necessary experience; in order to make this undertaking one which promotes healthy personality development, the committee believes that the young person must be prepared through—

A. Health.

B. Adequate schooling and guidance.

C. Qualifications for the job. Such employment be carried on under conditions which protect his best interests and allow the experience to be a satisfying, useful, and constructive one; such conditions include—

1. 16 year minimum age for work during school hours and for employment in manufacturing and mechanical industries at any time, and a higher minimum age for hazardous employment.
2. Basic age of 14 for employment after school and on vacation.
3. Protection from employment which is hazardous to health, safety or morals.
4. Limitation of combined hours of school and work, through High School

and Minors are carrying the double burden of School and employment.

5. Strict regulation of the daily and weekly hours of work with due regard for the varying needs of young people at different ages; efforts to reduce, in so far as may be practicable, the working week of young persons and children not attending school to not more than 40 hours a week and 8 hours a day.

Recommendation 6. In a world of conflict, we as a group, recommend that employers be urged to hire and give all advantages of training and advancement enjoyed by other employees to youth subject to all to the armed services and those in Reserves.

Steering committee recommendations:

- F. Minimum wage laws patterned after Federal FSHA as nearly as economic conditions permit.
- G. Special attention to safety of young people particularly in agriculture, through legislative training, and supervision.
- H. Workmans Compensation for minors in agriculture.
- I. Interested citizens groups initiate and support better enforcement of standards passed for protection of young workers.
- J. Cooperative councils on youth employment should be created.

Each State

- K. Set up vocational guidance training and placement for youth.

The groups met three times to arrive at their recommendations. These were turned over to a recommendations committee which watered them down to suit the tenor of the conference.

There were few resolutions on health problems except as incidental to healthy personality development. The medical profession was well represented and the general feeling was that the recommendations were of a solid nature.



PRESIDENT'S PAGE

L. J. Pankow, M.D.

January Message

At the annual meeting of the South Dakota State Medical Association last Summer, a Grievance Committee was created. Until very recently this was but a gesture, for altho the Members had been named and approved by the Council, not all the appointees had accepted. At this writing, however, all have accepted the responsibility and trust placed in them, knowing well that not only is it a thankless job, but that friendships may be destroyed by some future decision of the Committee.

Only Past-Presidents may be appointed for this very important work, for it was felt that such, having been given the highest honors that could be conferred by the Association, were of necessity men of proven integrity and adherence to the ideals of our Profession, and would thus be not only fearless in their actions to correct wrongs, but would have no fear for their own personal advancement. Truly, while the list of eligibles was not large, the only problem was to make a proper geographical distribution, for any one of our Past-Presidents was possessed of the necessary qualifications.

Heretofore any grievances that have come to our attention have been adequately adjusted, or, if grave enough, referred to the Council for action. Severe disruptions have been avoided, probably due to the fact that we were a small and well knit group. A rapid numerical growth and additional stresses of currency inflation and spiraling of wages on the one hand, and by the new and sometimes dangerous temptations incident to prepayment health insurance policies on the other, may well furnish grist for the mill of the Grievance Committee.

The Committee is Public Relations par excellence. To it, lay persons may appeal for redress for real or imagined wrongs by our members, knowing that just claims and complaints will be heard, and deserved censures administered. To it Doctors may appeal for protection and redress for unjust and unwarranted accusations and slanderous utterances.

It may even become the responsibility of the Committee to arbitrate differences between individual members of the Profession. Ill advised or poorly considered words of criticism against a Brother Physician may unleash floods of invective which so easily swell into bloated horrors that can split community, district, section or even The State Association into opposing factions, doing nothing to help the Practice of Medicine, and furnishing ammunition for our foes with which to snipe at our professional freedoms.

The Committee is your servant and your arbiter. It is to protect you from unjust injury — but its function is also to censure and criticise you if you are out of line. It will try in every way to reason with and properly inform your unjustified accusers, and will back you up with the staunch support of the State Association when it feels that you are in the right. If you are in the wrong it will try to correct your error and at the same time protect your interests, if you will conform to its suggestions and recommendations. Obstinate refusal on your part to cooperate with and abide by the wishes and suggestions of the Committee will, of necessity, result in a recommendation for punitive action against you by the State Association.

Only by full cooperation of every Member can we retain the position of trust and respect that our Profession deserves in the Commonwealth. Only by constant self discipline and careful watchfulness of our conduct and words can we be sure that our actions may not set off a chain reaction of circumstances that will weaken our defenses against the malignant forces rampant against us today. Only by carefully avoiding the probability of criticism against Dr. M. E. Myself, and worrying less about T.H.E. Other, M.D. will your Grievance Committee find their assignment an easy one.

If you have troubles brewing on your horizon by unjust complaints of a patient or of another person, be he layman or physician, or if you have troubles to bring before the Committee, unburden yourself. Lay it on the lap of you Grievance Committee. Write all about it to this Committee, care of the State Secretary, Executive Offices. 300 First National Bank Building, Sioux Falls, South Dakota.

EDITORIAL PAGE

"THE GRASS GROWS FROM THE CEILING"

In December we (the editorial "we") attended the Midcentury White House Conference on Children and Youth which was billed as a "grass-roots" conference on the personality development of young people.

Unfortunately, like so many non-spontaneous conferences planned by federal agencies, the results of the deliberations had been decided before the delegates attended a meeting.

We are not criticizing all of the results of the Conference; we just don't feel that the meeting should have been held merely to confirm the theories of the people who planned it.

In one work group, the sentiment of the group of individuals (a minority at that) was ably expressed by a priest who commented that if the meeting to that point was a grass roots affair, "the grass now grows from the ceiling."

The social planners who forget which way grass grows should study the Father's remark.

The young people at the Conference in many instances were ignored or brushed aside by the people who "knew what was good for them."

One tortured youngster who had a great deal of intellectual honesty exclaimed that the problem of children was to stop the adults from worrying about them.

We love the youngsters that were at the meeting — they want to work — to struggle — to fail or succeed — and they don't want our world tied up with prohibitions titled security. They'll do all right — but the Mid-century Conference lost sight of the marvelous spunk of our youth.

We made a suggestion that the Conference be realistic and were slapped down with the righteous retort that we must be idealistic when we plan for children for the next ten years.

Can't someone convince these people that

our children happen to live in a realistic world?

Surely, the grass does grow from the ceiling.

OSCAR EWING'S LITTLE HELPER

The Daily Argus-Leader of November 14th carried an article which was rather shocking to the general practitioners. It was entitled: "Doctor Asks Medicine to Clean House." It concerned a speech made by Dr. Hamilton W. McKay of Charlotte, N. C., President of the Southern Medical Association, which the article stated is the second largest medical group in the country. The speech was made at the annual meeting of this association at St. Louis. Surely, in such a large association, the great majority of members are general practitioners and one wonders why a sixty-five year old urologist should be their president. Be that as it may, the meeting was well organized and the contents of the speech was read with avidity and promptly put on the wires of the associated press for the nation to read.

Dr. McKay said: "If the people can not convince themselves that organized medicine is taking vigorous steps to correct its own shortcomings, they will insist that the initiative for action be transferred to other hands." What the shortcomings are he forgot to mention, or the associated press deleted them from the blurb. He continues: "We should improve the Medical Practice Acts, which in many states permit doctors to carry out procedures — operative or otherwise — for which they are neither trained nor competent." Then he continues, really hitting his strides: "I am not speaking about criminal abortion, violation of the Harrison Narcotic Act or other like offences. Neither am I thinking about the honest mistakes that each of us makes every day." This is what is called slander by inuendo. He manages to get the thought across that by far the greatest

number of general practitioners do an abortion quite often and by all means should be checked carefully by the narcotic agent. Then, this pundit continues: "I am referring to the medical man or surgeon . . . usually in the small hospital . . . who can not or will not make proper studies to arrive at a proper diagnosis." Since Dr. McKay is a 65 year old urologist, probably Board member by endorsement, just who is he to properly criticize general practitioners and general surgeons? Isn't the fact that he has grown respected and honored in the practice of referred urology quite good evidence that the general practitioners and the general surgeons in his locality have been wide awake to urological problems and have referred such problems to him? He is certainly taking a big bite out of the hands which feed him.

Then, he really takes off on a flight of fancy and drools: "The doctor who has a license to practice medicine and joins a county medical society is usually fixed for life. Unless he is convicted by a court for some criminal offense, he can continue to enjoy the rights and privileges of responsible doctors, even though he practices over-charging, neglect of patients and nonsupport of organized medicine." The old boy has practically all of us in jail. Just why, in the above diatribe, he left out the crime of snitching on income tax reports, I don't know. That would have looked good in the nations press too.

Dr. McKay is a Board member in urology and that is splendid. I would like to ask Dr. McKay, however, if the Board in urology or any other Board has any educational requirements which its members must meet from year to year, in order to retain members in good standing? So far as I know, only the Academy of General Practice have such educational requirements. Apparently Dr. McKay believes in annual examinations for all of us, in order to keep our medical licenses active. Could HE pass such an annual examination? There are few perfect human beings and fewer perfect organizations. But the principle of washing ones dirty linen in private is still good and sound. Dr. McKay had a perfect right to criticize us in his speech, if he felt that way. But to make unjust and adverse criticism public in the lay press can result in no good. I believe this

nasty blurb, by a fellow with good press connections, greatly increased the misunderstandings between the medical profession and that part of the nation which would like to see socialism in the United States. The excesses of the speech are such that I can't help but wonder if it was written by one of Ewing's 65 speech writers. Furthermore, it wouldn't be at all surprising, if more urological competition in Charlotte is arranged for in the near future.

J. A. Kittelson, M.D.

GULLIBLES TRAVELS

Gullible feels fine now. On December 1, he went to Washington, the home of organized confusion, to attend the White House Conference on Children and Youth. A report of the conference is printed elsewhere in this issue so it is unnecessary to go into the lurid details here.

However, on December 4, stopped in to visit **Senator Karl Mundt** and his staff and discussed the "doctor draft."

On the same day visited with **Rep. Harold Lovre** and his staff.

December 5, saw me in the offices of **Dr. Frank Wilson** of the A.M.A.'s Washington staff and in the V.A. medical and finance offices.

Stopped in Cleveland on December 7, to attend the conference on the National Education Campaign of the A.M.A., where I saw our delegate, **H. Russell Brown, M.D.**, participating in the decision to appropriate A.M.A. funds for medical education.

Arrived home the morning of December 9, in time to schedule a meeting of our Procurement and Assignment Committee for Huron the next day. **Drs. Van Demark, Hare, and McCarthy** were there to instruct selective service on the essentiality of twenty-eight registrants.

December 14, in the evening — spoke to the Augustana Press Club on "Public Relations of Trade and Professional Associations." **Ralph Hillgren**, of the Argus-Leader made the arrangements.

Gullible ran for the legislature and was elected. How gullible can Gullible get?

This is



JANUARY
1951
Vol. 4 No. 1

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

ALLERGISTS TO MEET NEXT MONTH IN CHICAGO

The American College of Allergists will hold its seventh annual meeting at the Edgewater Beach Hotel, Chicago, Illinois, February 12-13-14, 1951. This year these will be section meetings: Psychosomatic aspects of allergic diseases, under the leadership of Harld Abramson, M.D. of New York; on Pediatrics, under Bret Ratner, M.D. of New York; on Allergies of the Nose and Throat, under George Shambaugh, M.D. of Chicago; on Allergic Diseases of the Skin, under Rudolph Baer, M.D. of New York City; and the Allergic Aspects of Rheumatism and Arthritis, under George Rockwell, M.D. of Cincinnati, as well as a general session of the College when hay fever, asthma and the newer drugs will be discussed under the leadership of John Mitchell, M.D., of Columbus, Ohio, the President of the College.

This year the College is trying for the first time the experiment of offering its post collegiate instructional course on the three days just preceding its annual conclave. This course has been arranged with the thought in

mind that 10% or more of all the patients in a physician's practice have an allergic component in their complaint. (The faculty consists of some 25 outstanding allergists.) The course is therefore an extremely practical one designed for any physician who wants to learn the basic principles of diagnosis and treatment of allergic individuals and techniques that are useful in the management of these patients. A fee of \$35.00 will be charged for the three-day course lasting through February 9-10-11. For further information and registration write Fred Wittich, M.D., Secretary-Treasurer, American College of Allergists, La Salle Medical Building, Minneapolis, Minnesota.

MISSISSIPPI VALLEY MEDICAL SOCIETY 1951 ESSAY CONTEST

The Eleventh Annual Essay Contest of the Mississippi Valley Medical Society will be held in 1951. The Society will offer a cash prize of \$100.00, a gold medal, and a certificate of award for the best unpublished essay on any subject of general med-

ical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents and citizens of the United States. The winner will be invited to present his contribution before the Sixteenth Annual Meeting of the Mississippi Valley Medical Society to be held in Peoria, Ill., Sept. 19, 20, 21, 1951, the Society reserving the exclusive right to first publish the essay in its official publication — the MISSISSIPPI VALLEY MEDICAL JOURNAL (incorporating the RADIOLOGIC REVIEW). All contributions shall be typewritten in English in manuscript form, submitted in five copies, not to exceed 5,000 words, and must be received not later than May 1, 1951. The winning essays in the 1950 contest appear in the January 1951 issue of the MISSISSIPPI VALLEY MEDICAL JOURNAL (Quincy, Illinois).

Further details may be secured from

Harold Swanberg, M.D.,
Secretary,

Mississippi Valley Medical Society,
209-224 W. C. U. Building,
Quincy, Illinois.

EDUCATION CAMPAIGN MEETS IN CLEVELAND

The Third Annual Conference of the National Education Campaign of the American Medical Association was held in Cleveland at the Statler Hotel December 7th. **H. Russell Brown, M.D.**, Watertown, and **John C. Foster**, executive secretary of the South Dakota State Medical Association represented South Dakota at the meeting. The program started with a review of last years campaign and a discussion of the coming year by **Elmer L. Henderson, M.D.**, President of the American Medical Association.

Dr. Louis H. Bauer, M.D., Chairman of the Board of Trustees, of the American Medical Association spoke on "Legislation Affecting Medicine."

Dr. E. E. Irons, M.D., Past President of the American Medical Association spoke on "The Challenge Ahead." **Leone Baxter**, General Manager of the National Education Campaign spoke on "The Public Significance of Medicine's Advertising Campaign." **R. B. Robins, M.D.**, Vice President of the American Medical Association introduced **James A. Waggener** of Indiana, **Leo Brown** of Pennsylvania, **Charles Lively** of West Virginia, and **M. C. Smith** of Nebraska who discussed "Participation of State Societies in Medicine's National Campaign."

Clem Whitaker, National Education Campaign Direc-

tor, spoke on "Medicines Campaign Objectives for 1951." A presentation entitled "Socialized Medicine is No Bargain" was presented on behalf of **William L. Hutcheson**, President of United Brotherhood of Carpenters and Joiners of America.

The meeting was closed with a reply to Mr. Hutcheson's presentation by the president-elect of the American Medical Association, **John W. Cline**.

AMERICAN MEDICAL WRITERS' ASSOCIATION TO MEET IN PEORIA, ILL., SEPTEMBER 19, 1951

The Eighth Annual Meeting of the American Medical Writers' Ass'n will be held at the Pere Marquette Hotel, Peoria, Ill., Sept. 19 during the sixteenth annual meeting (Sept. 19, 20, 21) of the Mississippi Valley Medical Society in that city. At the recent meeting of the association the following officers were elected for 1951. President-Elect, **Dr. Arkell M. Vaughn** of Chicago, Vice-President, **Dr. Jacob E. Reisch** of Springfield, Ill., Secretary-Treasurer, **Dr. Harold Swanberg** of Quincy, Ill., members of the Executive Committee to serve two years: **Dr. J. DeWitt Fox**, Washington, D. C., **Mac F. Cahal, J. D.**, Kansas City, Mo., and **Dr. Lee Van Antwerp**, Chicago; to serve for one year, **Dr. C. W. Schumacher**, St. Louis. **Dr. Julis Jensen** of St. Louis is the 1951 president. Beginning in January 1951 the Association will publish a quarterly bulletin under the editorship of **Dr. Lee D. Van Antwerp**.

The association will pub-

lish its 1951 membership booklet in February and is desirous of securing as members all physicians interested in any phase of medical writing. Any A.M.A. member who has published two or more articles, indexed by the Quarterly Cumulative Index Medicus, is eligible for membership. Further details may be secured from the Secretary, **Harold Swanberg, M.D.**, 510 Maine Street, Quincy, Ill.

MEDICAL EVANGELISTS PLAN POST-GRAD MEET

"Diagnosis, Management, and Whats' New" will be the theme of the Annual Post-graduate Convention of the College of Medical Evangelists School of Medicine, to be held at the Biltmore Hotel, Los Angeles, March 11-16. The meeting is open to all graduates of recognized medical schools. Over 2,500 are expected to attend.

The meeting will be geared to the needs of the general practitioner, having been planned by a committee of general practitioners and medical school faculty.

Many eminent medical speakers will bring practical and comprehensive syntheses of latest advances in medicine which can be put to immediate use. Formal credit will be granted in the American Academy of General Practice.

Registration fee is \$10.00 and \$15.00 for the special courses. Information may be obtained by contacting **Jerry L. Pettis, M.D.**, White Memorial Hospital, 312 North Boyle Avenue, Los Angeles 33, California.

NEWS NOTES

The Cancer Society of the State of South Dakota has awarded \$2,000.00 for a continuation of the study of the phyto-pharmacological effects of cancerous blood. This project is under the direction of **Doctor Donald Slaughter** and **Doctor John Winter** of the Department of Botany.

A renewal grant from the United States Public Health Service has been made to **Doctor Earl B. Scott**, Assistant Professor of Anatomy and **Doctor Charles Schwartz**, Research Associate Professor of Biochemistry, to continue their work on the relationship of essential amino acid, calcium metabolism and cancer.

The State Tuberculosis Society has made an award of \$500.00 to **Doctor Harold N. Carlsile**, Chairman of the Microbiology Department, for a project devised to improve diagnostic methods in tuberculosis.

Frank A. Rudolph, M.D., Rapid City, has closed his office to take a three year surgical research position at Ohio State University, Columbus, Ohio.

Dr. Rudolph has been located in Rapid City for the past four years.

THIRD DISTRICT MEETS IN ARLINGTON

Thirty-six members, auxiliary and guests of the Society met in the Arlington Auditorium at 6:30 P. M. for dinner. Following, **Dr. Lyndon M. King, Jr.**, of Sioux Falls presented a lantern

slide illustrated lecture on "Common Skin Diseases" before the Society, while the Auxilliary met at the home of **Dr. Donald Scheller**.

The regular business meeting was called to order by **President Austin**. The minutes of the last previous meeting were read by the Secretary. Approved. The treasurer reported a bank balance of \$91.72. Moved by **Dr. Watson** and seconded by **Dr. Whitson** that the Third District participate in the State and National Essay contest as in prior years under the direction of the same committee and with the same prizes to be offered. Carried.

The following officers to serve for the year 1951 were duly elected:

President:

Dr. Donald Scheller
Arlington

Vice-President:

Dr. E. T. Plowman
Brookings

Secretary-Treasurer:

Dr. C. M. Kershner
Brookings

Delegates:

Dr. Magni Davidson
Brookings

Dr. Clarence Sherwood
Madison

Alternates:

Dr. Alonzo P. Peeke
Volga

Dr. Dean Austin
Brookings

Censors:

Dr. J. M. Muggly

Dr. Myron Tank

Dr. Robert Henry

Dr. Whitson read a letter urging members to contribute and solicit funds for medical schools, particularly the University of South Da-

kota; this in order to make unnecessary government participation and interference.

Drs. Boyd and **Benjamin** invited the next scheduled meeting for February 8th to be held in Flandreau.

Adjourned.

Signed C. M. Kershner, M.D.
Secretary-Treasurer

McKENNAN CLINIC DRAWS LARGE CROWD

Nearly 100 physicians from Sioux Falls and surrounding area attended the annual McKennan Hospital Staff Clinic at the hospital, November 27.

Speakers included **Drs. Ogborn, Billion, Jr., Greenfield, Manning, Billion, Sr., Cotnam, Billingsley, Breit, Hyden, Kohlmeyer, McGreevey, Arneson, Volin**, and **Stern** of Sioux Falls, and **Dr. J. M. Hermanson** of Valley Springs.

F. A. RICHARDS, M.D. 1872-1950

F. A. Richards, M.D., age 78, passed away at his home in Sturgis on November 27. Dr. Richards had been a member of the South Dakota State Medical Association until his retirement.

He had practiced since 1899 when he graduated from the University of Illinois Medical School. Twenty years of that practice were spent in White-wood, South Dakota and the rest in Sturgis.

Dr. Richards had been awarded the Medical Association 50-year Club Award just the week before he died.

SIoux FALLS DISTRICT ELECTS DOCTOR BREIT

Dr. Donald Breit, Sioux Falls was named president of the Seventh District Medical Society at the regular monthly meeting held at the cottage. **Dr. John V. McGreevey** was elected vice-president and **Drs. Manning** and **Reagan** were reelected secretary and treasurer respectively.

DR. LAMPERT ELECTED HILLS PRESIDENT

Dr. Arthur A. Lampert was elected president of the Black Hills District Medical Society at a meeting held in Deadwood December 14.

F. L. Williams, M.D., was named vice-president and **Harold J. Grau** was renamed secretary-treasurer. All officers live in Rapid City.

A discussion on civil defense was held in which plans for organization of doctors, nurses, and hospitals in case of disaster were discussed.

V. A. ISSUES INFO ON MALARIA CASES

The following ruling has been received from the V. A. and is published for the information of physicians treating V. A. patients.

Subj: Central Office check of positive smears for Malaria.

1. Attention is invited to Extension 7, Schedule for Rating Disabilities, 1945 Edition dated July 6, 1950, which is quoted below:

"Malaria. Add the following to note 2, Diagnostic Code 6304, Malaria, Page 65, (Extension 4, paragraph

13). 'Following the expiration of the 36 months' period and the veteran's compliance with the requirement to report as indicated above, a prepared slide of the veteran's blood smear will be read in the local VA laboratory, and if the interpretation is positive, the prepared slide will be mailed in a suitable container addressed to the Director, Veterans Claims Service, Central Office, with proper identification of the veteran, including C-number and time and place of smear, before further acceptance of the diagnosis, malaria, for rating purposes.' "

2. Examining physicians, including fee-basis physicians, will be informed of this requirement.

/S/ Paul B. Magnuson

Chief Med. Director

ANNUAL CLINICAL CONFERENCE OF THE CHICAGO MEDICAL SOCIETY

March 6, 7, 8, 9, 1951

Palmer House, Chicago, Ill.

The Clinical Conference of the Chicago Medical Society is designed to bring physicians new resources to meet their problems in every-day practice. A faculty of thirty-four outstanding speakers will present half-hour lectures and another group of authorities will participate in the four Panels on timely topics.

Each year the Society presents something new which will be of interest to those attending. The special feature for the 1951 Conference will be DAILY TEACHING

DEMONSTRATION PERIODS from 11:00 to 12:00 noon and 1:30 to 3:00 P. M. These will include demonstrations of Amputations and Prostheses, Patients Treated with ACTH and Cortisone, Dermatologic Clinic, Proper Application of Casts and Splints in Fractures, Fluid and Electrolytic Balance in Surgery, Local Anesthesia, Use and Misuse of Obstetrical Forceps, Organization of a Blood Bank, Neurological Clinic, Sterility tests, Common Problems in X-Ray Interpretations, Laboratory Tests including tests for diabetes and Proper Use of Insulin and Prothrombin Tests, and Speech without Larynx.

The scientific exhibits will be new and worthy of real study and carefully selected technical exhibits will prove helpful and time-saving.

Physicians who have attended previous Clinical Conferences know their value and will plan to attend in 1951. This Annual Conference should be a must on every physician's calendar as it has earned the reputation of being one of the outstanding medical conferences in the country.

MEDICAL SERVICES MEET SCHEDULED FOR CHICAGO

Twenty-fourth Annual Meeting of the National Conference on Medical Services will be held Sunday, February 11, 1951, in the Red Lacquer Room of the Palmer House in Chicago.

The meeting is of special importance to the president, secretary and public relations personnel of the State Medical Association.

PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor

UNITED ACTION AND PROGRESS

by Frank W. Moudry

President National Association of Retail Druggists

Mr. President, Members of the South Dakota Pharmaceutical Association, Ladies and Gentlemen, Friends:

It is always enjoyable to visit with good neighbors such as the druggists of the Sunshine State. I am glad to be here today to join in the convention activities of the South Dakota Pharmaceutical Association. The warmth of the hospitality that has been extended to me makes me happy to be with you.

The South Dakota Pharmaceutical Association in fortunate to have exceptional leadership. The organization will continue to make important contributions to the progress of pharmacy as long as you elect men of such caliber as President John Sidle, and Bliss Wilson. It seems to be in order for me to commend your secretary for the excellent cooperation the N.A.R.D. receives from him. He never passes an opportunity to be of assistance in connection with the national programs for the betterment of the independent druggists.

It is a pleasure for me to bring you greetings from the N.A.R.D. Our executive secretary, John W. Dargavel, and the other officers and members of the executive committee join with me to wish for you a profitable and enjoyable convention. We also hope that most of you will make the trip to Long Beach, California, in October to attend the convention of the N.A.R.D. I extend to one and all of you a personal invitation, with the assurance of a program loaded with ideas keyed to the realities of drug store operation and the problems of pharmacy. The Mayor and the Municipal Council of Long Beach write that they will leave nothing undone to insure a good time for everyone who comes to the

Play Spot of the Pacific to attend the convention of the N.A.R.D. I will look for a sizable number of druggists from South Dakota.

DISCOUNTS

Many problems confront us today. One that has troubled the retailer for five years has become acute. I refer to discounts.

Numerous discussions have been devoted to discounts. They have run the gamut of the arguments pro and con. I was much interested in an editorial in a recent issue of the N.A.R.D. Journal. It is a comment on the common contention that it is long past the time to revise most of the minimums. I quote the editorial as follows:

"It is common for spokesmen of a large number of manufacturers to insist that the costs of production make it impossible to add to the discounts. The rebuttal is obvious and simple and it puzzles us that it is ignored. The minimums can be increased to give the retailer the gross profit he needs.

"Manufacturers tell us that the reason they hesitate to revise minimums upwards is the probable reaction of the public. They fear lost sales would come with higher prices. The data they base it on is meager." (End of quote)

Then the editorial cites a product which retails for 57 cents. The margin on it is 21 per cent. Spokesmen for the producer contends it is the maximum that can be allowed. It costs the retailer about 28 per cent to handle the article. Elementary arithmetic reveals he takes a loss every time he sells the product. There are many similar cases and the total has pushed the retailer close to the verge of a downswing to bankruptcy. The truth is he has been made the goat of an unsound situation. Corrective measures are urgent and they have been neglected much too long. I am reminded of a story that sug-

An Address as delivered before the Annual Convention of the South Dakota State Pharmaceutical Association in Sioux Falls on June 14, 1950.

gests the attitude of manufacturers toward the druggist.

Up in Minnesota a locomotive killed a cow that belonged to a farmer named Sven Olson. About a week later a claim agent of the railroad called on Olson.

"I understand that the dead cow was a docile and valuable animal," the claim agent said to the farmer. "The railroad sympathizes with you over the loss of the cow. But, Mr. Olson, you must remember this — your cow wasn't supposed to be on the tracks. The tracks are private property and when she invaded them she became a trespasser. The railroad doesn't like to sue you. You have trouble enough already. Yet, Mr. Olson, you must admit the facts of the case. They are plain. Now then, how can we settle the claim?"

"Vell" Sven Olson said slowly, "Ay bane a poor Svede. De cow vas a good vun and she milk a lot. But yust de same ay give de railroad two dollars."

It is true that the N.A.R.D. has a project devoted to a study of Retail Drug Store Costs identified with distribution. The N.A.R.D. is a partner with the manufacturers and the wholesalers on the survey. From it we hope to procure factual information that can be presented to manufacturers showing the necessity for economic revisions of discounts. Also from the study may come data of value in connection with drug store operation.

The general pattern of the drug store cost of operation study was adopted on July 14 of 1949. Dr. Orin Burley of the University of Pennsylvania Warton School of Finance and Commerce was then named to head the project. He is a man of exceptional capabilities and he is an authority on the economics of distribution. The cost of the survey will approximately be \$150,000.

Here is what the study is intend to give us:

- (1) The overall picture of drug store operation nationwide.

- (2) Variations identified with geographical locations and sizes of communities.

- (3) The current factors that determine profits and losses.

- (4) Practicable information on drug store departments.

- (5) Facts that will provide guidance to manufacturers for revision of discounts.

I am confident that the project will prove

to be beneficial to the entire drug industry. There is reason to believe it will help to develop a better spirit of cooperation between the manufacturers, the wholesalers and the retailers. It is compulsory that there is teamwork among these three to insure the welfare of each group. For any one of the three to ignore the interests of the **other** is to create an unhealthy condition that is injurious to the individual members of the triangle. This is the first time we've had the cooperation of the entire drug industry to solve this problem.

Another development of the past year was the establishment of the N.A.R.D. Bureau of Education on Fair Trade. It has already sustained the judgment that urged the formation of such an organization for the enlightenment of the consumers on the advantages of stabilized prices. The money to finance the planned activities of the agency for **three** years is either on hand or it is assured. I am elated over the responses of the druggists to the appeal from the N.A.R.D. office for contributions to the treasury of the Bureau to carry out the Fair Trade program. It was felt that if the retail druggist made a contribution he would become more interested in the fight to save Fair Trade. The total received as of December 31, 1949, (the date of the latest report) is \$60,510, or more than twice the N.A.R.D. quota for two years.

The current program for the defense of stabilized prices is for a period of three years, and it has been estimated that the needed funds for the period will amount to \$360,000. The manufacturers are expected to cover \$120,000 of the total, the wholesalers a like sum, the members of the N.A.R.D. \$90,000, and \$30,000 from the National Association of Chain Drug Stores.

The N.A.R.D. Bureau was formed on July 1, 1949, after a special committee had submitted a report on an intensive study of the nationwide situation and the factors that had to be overcome in order to insure the preservation of Fair Trade. Since then much has been accomplished. The problem of funds has been solved and we have mobilized a determined army of support for the planned activities. Numerous leaders of groups opposed to stabilized prices have been convinced that they were wrong and they are now favorable towards Fair Trade. Facts

have been gathered which are essential to development of an effective program. Work has been started on material for the guidance of action teams and the education of the consumers. The pilot test in Rhode Island has been completed and from it we have procured valuable information. The data that was gathered is now being used in the preparation of a packaged program for public relations activities devoted to the public on the benefits the consumers derive from Fair Trade.

There is a situation that can bring about the ruination of Fair Trade. It is numerous violations of the resale contracts. Two things must be done to eliminate the hazard.

(1) It is necessary for the manufacturers to enforce their Fair Trade contracts.

(2) The retailers must never deviate from the terms of the resale contracts.

Some of the manufacturers overlook the obligation they assumed the moment they placed their products under the protection of Fair Trade. It is much less than enough to do nothing more than stipulate minimum resale prices. Violations must be enforced or they will grow until they are common and then the result is bound to be the end of Fair Trade.

Retailers with negative attitudes towards resale contracts constitute a menace to the system of economic prices. It is important to enlighten them on the consequences that are certain to come with numerous violations of Fair Trade.

Recently in New York City the Macy Department Store touched off a court action that involves Fair Trade. The huge mercantile store slashed prices on electrical housewares, (irons, toasters and grills) below established minimums. The management of Macy's is an avowed enemy of Fair Trade. It has fought the system of stabilized prices for many years.

General Electric took action against the huge mercantile store to compel compliance with established prices on the irons, toasters and grills the company produces. The court granted a temporary injunction to restrain Macy's. It is to be followed with a suit to procure a permanent injunction.

General Electric is to be commended for the action. The company has thereby manifested a sincere belief in Fair Trade.

COMPETITION AND MERCHANDISING

The buyer's market has baffled many druggists. They seem unable to make the necessary adjustments and the result is lost sales. They must cope with it or they will cease to be drug store owners. It has been estimated that 10,000 druggists will pass from the retail field in the next five years through failure to merchandise. I do hope that none of you will be among them.

You may have heard about the mistake an antique dealer made. He assumed that a certain villager was simple. So when he saw a cat lap milk from a china saucer of unusual design, the antique dealer decided he could buy the valuable saucer for a song. First he would deal for the cat. Five minutes later he had the cat for \$10. Then he said to the villager, "The cat will settle down faster with the saucer. I'll give you fifty cents for it."

The villager replied, "Nope, I ain't of a mind to sell the saucer. The cat you just bought is the eighth I've sold with the help of the saucer."

Competitors we have to contend with are clever and we have to be alert to hold our own. Business promotion is compulsory. It includes: (1) a clean drug store, (2) professional atmosphere, (3) competent salespeople, (4) attractive window and interior displays, (5) effective newspaper promotion, (6) direct mail, (7) public relations — and these coordinated with the best of service.

Business promotion has many outlets. I have selected one of them to discuss here today which is of particular importance and moreover, it is often neglected. I refer to public relations.

Public relations involve the things we do to please the customers in our drug stores and the personal interest we take in the activities of the community in which we live. Just a few days ago a friend told me that he had been identified with civic affairs for 27 years and in that length of time he had seen only two druggists take an active interest in community betterment, and he included public health problems. I replied that I knew of more than a few druggists with unusual records of participation in civic affairs. However, the point is that we can do more than we have in the past to improve community conditions. Thus we increase the prestige of

pharmacy while we receive the pleasant rewards of individual satisfaction.

In this connection it may be remarked that the individual drug store proprietor can through operation of the type of drug store in which people like to trade can do more to improve public relations than anything else that can be done. The attitude of the public toward pharmacy as a whole is but the reflection of the opinion each person has of that part of pharmacy he sees — the neighborhood drug store he patronizes. It is up to all of us to make certain that the reflection is of a community health center.

INTERPROFESSIONAL RELATIONS

The N.A.R.D. has just completed a survey on interprofessional cooperation between the physicians and the druggists. The information accumulated to date shows that the state and local pharmaceutical associations had to take the initiative to bring about better relations with the doctors. Success attained here and there over the country came from leadership that refused to be discouraged. Furthermore there are substantial indications that the menace of socialized medicine has done much to help increase interprofessional cooperation and for that reason doctors have become more responsive. The overall picture has improved to a considerable extent since 1945.

CLINIC PHARMACIES

The problem of pharmacy service in clinics owned by physicians has become serious in some sections of the country. The doctors identified with the clinics seem to care little that they are competitors of the druggists in the same areas they serve. The pharmacy service of the clinics is defended on the supposed grounds that it is beneficial to patients. Many of us have grave doubt that it is in the best interests of the public welfare. We recognize that group medical practice has certain advantages. Nevertheless we feel that the physicians should leave the ownership and the operation of pharmacies to pharmacists. One has only to look ahead a short distance to see what would happen to our profession were pharmacy service to become general in clinics over the whole country.

Organized pharmacy should impress on the medical profession that this encroachment on pharmacy is contrary to the welfare of the public and also perhaps to the medical pro-

fession. Pharmacy is on record with medicine in opposition to any legislation, state or federal, that deprives the sick of free choice of physicians. Yet in the operation of pharmacies in clinics, the doctors take from the patients the free choice of pharmacists. This is a serious situation and it requires tact and diplomacy to correct it. I am of the opinion that the logical approach to this problem is to work through the state medical societies.

PHARMACY LAWS

There is another regrettable situation. It is the obstruction we encounter in connection with efforts to bring about enactment of better pharmacy laws in the various states. The legislation is essential to pharmacy and to the general welfare and public health of the people. Yet we have to contend with opposition from within the drug industry which refused to consider the protection it is necessary to have in order to safeguard the public from hazardous distribution of drugs and medicines. The most militant opposition is that of the Proprietary Association. The organization appears to favor laxities that made it easy for the bygone patent medicine vendor to peddle nostrums to gullible people. Experience emphasizes that it is necessary to have legislative restrictions to curb ruthless commercial operations in the health field. Charlatans are unscrupulous and from the sick they filch huge sums of money. It takes laws and determined enforcement to cope with the agencies of quackery.

We seek to bring about the enactment of better pharmacy laws, nationwide, which will insure the safety of the public. The legislative restrictions we advocate are in line with the general welfare. Many state associations, when they have attempted to bring about enactment of pharmacy laws, have been confronted with manipulations directed from the headquarters of the Proprietary Association. It is evident to me that to move forward, it is necessary to counteract the forces arrayed against us — and to do it, we must mobilize the maximum strength it is possible for us to muster. The druggists of the country have the power to overcome the opposition to better pharmacy laws. It is for us to use it with enlightened and intelligent determination.

SOCIALIZED MEDICINE

One of the objectives of the N.A.R.D. is to

oppose any plan that in operation will deprive medicine and the allied medical professions of their private enterprise status and take away from the public the full right to individual selection of physicians, dentists and pharmacists.

I wish to touch on it here because the issue of socialized medicine continues to make headlines.

The advocates of socialized medicine seem to care little about facts and they throw statistics around with unbelievable indifference to their accuracy.

The public must be told the truth about the cost of socialized medicine. How many people have even a vague idea of the additional burden of taxes the proposed national health insurance program would make necessary to finance the scheme? Only a small number are aware that before long it would take about \$190 a year in taxes to pay for each person or a total of more than \$25 billion per annum. The weight of that huge sum has been minimized for deceptive reasons. It must be made known to the public. It is an obligation of citizenship for us to help inform the people on the cost of the proposed national health insurance program.

Furthermore, there is the horde of boards, inspectors, auditors and investigators necessary to administer the scheme. They would constitute a bureaucracy certain to put medicine and the allied medical professions, inclusive of pharmacy, into a straitjacket of government control. The consequences would include strangulation of medical progress in America.

You have been told on various occasions that the druggists have nothing to fear from socialized medicine. The sponsors of the scheme have even tried to make you believe that it will increase the business of every drug store in the United States.

The obvious intentions are to deceive us through appeals to selfish interests. Moreover they seek to induce us to overlook the realities of government regimentation of pharmacy.

The N.A.R.D. is opposed to socialized medicine for the following reasons:

1. It is a panacea compounded in accordance with the theories of Marxism.
2. It requires a dictatorial bureaucracy to function.

3. It costs enormous sums of money to finance.

4. It hamstring the progress of medical science.

5. It provides an inferior quality of medical care.

WASHINGTON ACTIVITIES

The N.A.R.D. strives to serve the druggists through activities identified with politics in the capital of the nation.

Politics has become one of the major factors that determine the courses of business. You may bemoan the transition and it perhaps infuriates you to have to contend with a conglomeration of government regulations and numerous instances of bureaucratic interferences. Nevertheless, they appear to be components of a complex industrial society.

Accordingly, we must take much more than a haphazard interest in politics to hold them inside the boundaries that insure freedom of enterprise and the way of life that is the United States.

Men in business are inclined to deride bureaucratic interferences and government regulations. Sometimes they are positive that the nation is on a downward road to the swamps of Socialism. Many of us have failed to realize that it is folly for men identified with business to refuse to make personal contributions to politics.

Politics determines the structure of the government. It marks the trails the nation is to travel. It draws the blueprints of the social order we are to have in the future. It writes the laws we must obey. It embraces the whole economic structure of the country. It is downright stupidity for men of business to do nothing more than be grandstand spectators of politics.

The N.A.R.D. is in politics and it has been ever since it was established. Through the organization **you** can be effective in political activities directed toward solutions of various economic problems. Furthermore, you can center militant and unified action against programs that are destructive to small business and freedom of enterprise.

Most of you have followed the fight on the bill identified as S. 1008. You know, of course, that it has passed both the House and the Senate.

The measure had behind it the strong pressure of the monster industrial concerns and

also many lesser firms that for reasons of survival are afraid to oppose the schemes of the monopolistic combinations. The spearhead of the campaign aimed to bring about the enactment of the bill was composed of the lesser firms. The large companies were in the background.

The defenders of small business had to contend with the power of the monster industrial concerns. It was too much for us to counteract. One of the principal reasons was the failure of the independent retailers to muster the strength they possess. The majority of them never made even a gesture to help wage the battles to save the federal statute against hidden discounts, secret rebates and other forms of price discrimination that are destructive to small business. Only a minority of the independent retailers bothered to contact the members of Congress. It is evident indeed that a tragic number of druggists have yet to learn the essentials of united action.

S. 1008 passed the House in amended form on March 14. It was still unsatisfactory. Then on May 25 it was called to the floor of the Senate. The debate that followed was heated and bitter.

The vote on S. 1008 came on June 2. It was 43 to 27 to pass the bill. On the showdown 30 Republicans and 13 Democrats joined to bring about the enactment of S. 1008. Only 2 Republicans (Alexander Wiley and Joseph McCarthy, both of Wisconsin) were present to vote against the measure.

(Ad lib on action of President Truman)

I note that both the representatives in Congress from South Dakota (Harold O. Lovre and Francis Case) voted in favor of S. 1008. Senator Chan Gurney was paired in favor of S. 1008 and Senator Karl S. Mundt gave a vote on the bill against small business.

Another bill of immediate interest is known as H. R. 4203. It was introduced for the N.A.R.D. by Representative Carl T. Durham, a pharmacist, from South Carolina. The proposal is offered as an amendment to the Food, Drug and Cosmetic Act. It would eliminate the confusion of government regulation over prescriptions, and with it return the traditional relationship between the patient and the doctor and the pharmacist. H. R. 4203 is yet to be reported.

We may have to accept changes in the bill.

However, none of them will modify the purpose of the measure.

NEW COMPETITION

Various types of outlets have invaded the drug field and to them the druggists lose a large volume. It is now common for grocers, super markets and variety stores to sell many products that once were exclusive to the pharmacy. This competition is another of the serious problems with which we have to contend.

Unfortunately the pharmacy laws of all the states have a provision in the law which reads in substance as follows: "Nothing here shall apply to or interfere with the manufacture, wholesaling, vending, or retailing of non-habit forming, harmless proprietary medicines when labeled in accordance with the requirements of the State or Federal Food and Drug Act."

Under this provision it is legal for outlets other than licensed drug stores to handle virtually all the patent and proprietary medicines that you sell in your drug stores. You can guess what will happen to your sales of these items when the supermarkets, grocery chains, independent food and variety stores, confectioneries, taverns, beer joints, pool halls and other outlets really go after sales of these products.

Recently I had an opportunity to confer with the management and legal counsel of a large chain grocery in an effort to discourage them from entering the drug field. I was able to give them many reasons why it was not in the best interest of the public health and welfare, and the possible harm that may come to the public when drugs and medicines are distributed and sold promiscuously by persons minus necessary qualifications and untrained in the knowledge of drugs. They frankly admitted that drug stores under the supervision of pharmacists are the logical places for the sale of these items. But again they emphasized they needed additional profits.

In the future your competitor will not be your fellow pharmacist. You will be in competition with the many stores in your town or community which will add patent and proprietary medicines to the drug sundaries and toilet articles they now sell.

We are told that the housewife shops in the supermarket and grocery store ten times to one trip to the drug store. It is reasonable

to assume that she will purchase her drug needs when she buys groceries.

About the only difference between these stores and your drug store will be that you are permitted to compound prescriptions. This picture certainly should arouse the retail druggists and inspire them to support their local, state and national associations as a well organized group. We can pool our efforts and abilities to bring about the passage of pharmacy legislation which will protect the public and the profession of pharmacy by restricting the sales of drugs and medicines to those who are qualified.

N.A.R.D.

Organization is vital to us. Yet there is a sizable number of drug store owners content to be only spectators and they refuse to become identified with national, state and local associations of druggists. Somehow we must disabuse their minds of notions that deprive us of the additional strength we must have to cope with the serious problems we face. **It is compulsory for us to be strong.**

The history of pharmacy stresses the importance of organization. Before the N.A.R.D. was founded, the majority of the druggists had been pushed to the precipice of bankruptcy and there seemed to be only meager chances they could survive. The dynamics of the times ran against them. Nobody outside the profession of pharmacy was interested in the plight of the drug store owners. Furthermore, the manufacturers of proprietaries, on whom the druggists then were dependent to a large extent, with but few exceptions, followed wolfish business policies. The physicians also displayed callous indifference toward the struggles of the drug store owners to exist. Then to make the situation worse, only a small number of druggists recognized the power of organization.

Various efforts were made to unite the drug store owners to enable them to strive together to overcome the economic problems that surrounded them. Nothing much was accomplished due to the failures of the druggists to comprehend the essentials of effective united action. They had to go through additional hardships to learn the primary lessons of concerted activities.

October 17, 1898, is a historic date to the druggists of America. It marks the formation of the N.A.R.D. in St. Louis.

Through the years since then it has proved on numerous occasions to be the organization the druggists had to have to survive the gyrations of change and the complexities of economic fluctuations. It has provided the machinery of effective concerted activities and the leadership essential to accomplishment through unified action. The records tell you that it has been a major factor in the advancement of pharmacy and the retail drug business.

Every retail druggist should feel it a privilege to be a member of the N.A.R.D. It is an organization that strives to preserve the way of life born of freedom. It is a guardsman for the independent retail druggist.

Today the N.A.R.D. is financially sound. It has more than six hundred thousand dollars in the treasury. It has a membership of over thirty thousand druggists. The activities of the organization are extensive and effective for the advancement of the independent drug store owners and the profession of pharmacy. Much of the credit for the progress that has been made since 1933 belongs to the exceptional management provided by the executive secretary, John W. Dargavel.

Today freedom of enterprise is under attack from many sides here in America. How much have we druggists done to help defend it? **Too little.**

To save freedom of enterprise we must insure it a favorable political climate. The majority of businessmen of every category has failed to give this fact more than casual thought. The consequence is that they have defaulted the economic system of capitalism.

The enemies of freedom of enterprise preach that the millenium will be reached with the removal of the capitalistic system. They sneer that businessmen think only of profits and that we must be exterminated to enable the masses to escape from the desparation of poverty. Millions of people have been deluded to believe the fraudulent arguments of Marxism. It is a tragic reality here in the United States.

Histroy warns us against the trend we see today in America.

We businessmen of drugdom have a story to tell that upholds freedom of enterprise. We have neglected to enlighten the public and many of them have been deceived to believe that economic salvation is attainable only

through upheaval of our present form of government and the establishment of a socialistic society, or the uglier form of Marxism known as Communism.

I conclude with a statement that to me is of fundamental importance: The retail druggist in addition to selling merchandise has an even greater commodity to sell. The commodity of which I speak is the way of life called America.

(Continued from Page 17)

of lymphoma of the left hilum was made and x-ray treatment recommended (figure 6a.) Re-examination on September 9, 1948, shows no change and x-ray treatment was again recommended for therapeutic trial (figure 6b.) X-ray therapy was instituted on September 28, 1948. The film of October 4, 1948, shows no change in the lesion (figure 6c.) Re-examination on October 25, 1948, reveals a definite decrease in the tumor and it was considered to be probably a lymphoma (figure 6d.) The film of December 20, 1948, again shows an increase in size of the lesion (figure 6e.) Bronchoscopy was done in February, 1949, which demonstrated a tumor, probably an adenoma, on the left. In March, 1949, an exploratory thoracotomy showed the tumor to be an adenocarcinoma, cylindroma type, and a left pneumonectomy was performed. The last film of September, 1950, demonstrated the post-operative chest with no evidence of recurrence to date (figure 6f.) This case illustrates the sometimes asymptomatic carcinoma, the varying rate of growth that occurs, and especially the fault in prolonging therapeutic trial by x-ray beyond the recommended four weeks limit before definitive treatment is instituted.

BIBLIOGRAPHY

- Adams, Ralph: Diagnosis and Treatment of Lung Tumors. American Review of Tuberculosis. 59: 353-363, April, 1949.
- Ariel, I. M., Avery, E. E., Kanter, L., Head, J. R., Langston, H. T.: Cancer 3:229-239, March, 1950.
- Macht, S. and Perlberg, H.: Use of Anticoagulant (Dicumerol) in Preventing Post-Irradiation Tissue Changes in the Human Lung. American Journal of Roentgen and Radium Therapy 63: 335-341, March, 1950.
- Johnson, C. R., Clagett, O. T., and Good, C. A.: The Importance of Exploratory Thoracotomy in the Diagnosis of Certain Pulmonary Lesions. Surgery 25: 218-230, February, 1949.

(Continued from Page 21)

6. This unsavory situation could be greatly improved by sharply delineating between the hospital service of maintaining and providing technical services in the specialities in question, and medical service and practice of interpreting the technical details and rendering a medical conclusion and opinion from them.

7. Conclusion of conclusions: This problem is one helova big headache, and I am certain that mine is undoubtedly far from the ultimate solution.

In his immortal book, Henryk Scienkiewicz writes of the Apostle Peter fleeing the horrors of Rome and abandoning his duty to himself and mankind. He meets the Spirit of his Master, going toward Rome to take up the obligations Peter had left. Peter cries out "QUO VADIS, DOMINE?" — "Where goest Thou, Master?"

I have titled my paper "HOSPITAL SERVICE VS. MEDICAL PRACTICE" or "Quo Vadis."

IF YOU MOVE —
PLEASE NOTIFY THE
JOURNAL OFFICE
300 First National Bank
Sioux Falls, South Dakota

DOCTORS ARE
URGED TO COOPERATE
WITH THE PHARMACISTS
ADVERTISING IN THIS
JOURNAL

Severe Fractures About the Ankle

Raymond Householder, M.D.

The purpose of this paper is to discuss with you our experience with severe fractures about and of the ankle joint and offer the method which has served us well in handling the more than ordinary problems presented. Fractures of the ankle are relatively frequent injuries which vary greatly in degree and severity and for the most part are due to indirect violence caused by abduction, adduction or torsion action of the leg while the foot is fixed on the ground. In other instances they are due to compression combined with the above forces in accidents which are due to fall from a height. Again there may be direct violence by compression or crushing. They may involve either or both malleoli, the articular surface of the tibia or both bones of the leg just above the ankle joint. They may be simple, complex or compound. The fragments may or may not be displaced. In this discussion I shall confine my remarks to such cases where there was marked comminution and displacement of fragments, some in which the joint surface was involved and some which were severely compounded.

When confronted with a patient who has sustained a severe ankle injury our first step is an evaluation of the problem with x-ray studies of the region and careful inspection of the soft parts, paying particular attention to whether or not the fracture is compounded and whether the blood supply and the viability of the tissues has been seriously compromised.

The first case is that of a railroad switchman who had just sustained a severe crushing injury when the lower end of the leg was run over by a freight car wheel. You will note the severe comminution of the lower end of the tibia and fibula and even on the x-ray study the soft part trauma that must of necessity accompany such severe bone injury. Anyone with even little experience can recognize that with such findings the circulation to the foot has been so destroyed that it is useless to attempt to save the injured

member and that a gillotine amputation is indicated. We prefer to do this simple amputation just above the crush as a primary procedure and later when the patient's general condition improves and clinically no infection is present to do an amputation at the site of election below the knee. Even though the first inspection leaves no doubt that amputation is necessary, I wish to stress the importance of having an x-ray study of the injured region as a matter of record, for the x-ray film is more eloquent than a word description of the findings in the event of possible subsequent medico-legal action.

An x-ray study of the ankle region of a salesman, age 37 years, who sustained this injury in an automobile accident. This was a compound comminuted fracture. We saw him for the first time six months after the accident and the slide represents the condition present at his initial visit to us. The initial treatment had been by skeletal traction by means of a pin through the os calcis and a pulley and weight at the end of the bed permitting the patient to twist and turn freely. There had also been infection with suppuration and draining sinuses were still present when we first saw him. The unhappy end resulted with posterior displacement, inversion, angulation and shortening indicated to us that this was not a satisfactory or suitable method of handling such a problem. Two and a half years after the accident the patient was still disabled and the condition as shown here is permanent. However, this man has made an excellent adjustment to his disability and is back at work in spite of the handicap.

This next case is that of a 47 year old painter who seven months prior to this film fell twenty feet from a scaffolding and in addition to this injury sustained a fracture of the left os calcis. This right ankle was operated elsewhere and according to the patient two metal screws had been inserted, one of which had been removed. This film represents the condition as we first saw him seven

months after the injury. There is only ten degrees range of motion in this joint and it is painful. You will note the eversion angulation of the ankle joint mortise. While there are undoubtedly many instances in which this type of procedure is satisfactory an end result as this does not appear to be a happy one.

Here is the case of an overweight 57 year old engineer who slipped and fell while descending from a locomotive cab and sustained a simple fracture of the internal and external malleoli with complete medical and posterior dislocation. Fortunately, this was not compounded and we saw the patient within an hour after the accident. Under intravenous sodium pentothal general anesthesia the fragments were manipulated and replaced. A circular plaster cast over light padding was applied from the toes to mid-thigh. This shows the results obtained; the dislocation reduced and the fragments in excellent position. Check-up x-ray studies three weeks later revealed this position maintained. If position can be preserved, the simple manipulation and plaster cast procedure provides an easy solution of this problem. This man went back to work eight months after the accident.

Here I wish to stress the point that the golden opportunity or moment to treat a fracture is **now**. Immediate or early handling of a fracture before swelling and soft tissue infiltration occur permits the best chance of satisfactory realignment of fragments and a happy end result.

Next is a case of a 53 year old attorney who while descending a ladder slipped and fell nine feet and sustained an injury to the right tibia and fibula a few inches above the ankle joint. This comminuted fracture was not compounded. Note that the fracture of the tibia is oblique, extends into the articular surface and that there is lateral angulation. Under general anesthesia the fragments were manipulated and a circular plaster cast applied from the toes to mid-thigh. This x-ray study immediately after reduction reveals the fragments to be in relatively satisfactory position. Check up x-ray studies at frequent intervals revealed the distal fragments becoming displaced laterally with an eversion angulation. The last of these two weeks after the injury shows the unsatis-

factory position even after a second manipulation and application of a plaster cast. The second cast was removed and the skin prepared for the application of an external fixation apparatus. This was applied 18 days after the original injury. Two pins were inserted transversely through the os calcis unparallel to each other. These were fastened together with clamps and a bar on either side of the heel. Two pins were inserted transversely but unparallel through the tibia about mid-shaft and fastened together with clamps and a bar on either side of the leg. The upper and lower pair of pins were then connected with clamps and long metal bars, the fracture manipulated and when a satisfactory position, as checked by x-ray, was obtained the clamps tightened. This was comfortably worn for eight weeks. During this time there was no infection of the soft parts or bone nor sloughing of the soft parts about the pins. After the external fixation apparatus was removed a circular plaster boot cast from the toes to three inches below the knee was applied for another four and one-half weeks. During this time the pin holes in the soft parts had completely healed. The result after the last cast was removed three and a half months after the injury. At the end of a year this man walked well without a cane, was back at work and had about 5% loss of motion in the ankle joint.

The next case is that of a 42 year old negro who sustained a simple comminuted fracture of the right tibia involving the distal four inches, invading the joint surface and a spiral oblique fracture of the fibula near its upper end. When first seen the fragments generally were in such satisfactory position that a circular plaster cast was applied from the toes to mid-thigh. A check up x-ray study five days later through the cast revealed a shifting of the fragments that predicted an unsatisfactory result if allowed to remain. The cast was removed, the skin prepared and under general anesthesia six days after the injury external fixation apparatus applied using two unparallel pins through the os calcis and two unparallel pins through the shaft of the tibia in the manner described in the preceding case. This was comfortably worn without complication for two months and ten days. Six months later, showed excellent new bone formation and the relatively

good position. At that time he was walking well and had 80 to 85% of full function of the ankle joint and was relatively comfortable. In another two months he had essentially full function and was comfortable.

The next is a 47 year old negro who fell about eight feet from a locomotive and sustained a simple comminuted fracture of the distal three to four inches of the right tibia involving the articular surface and with shortening, distortion and impaction. Note that there is also a fracture of the os calcis. Under general anesthesia two pins were placed unparallel through the os calcis, two pins unparallel through the shaft of the tibia, the fragments manipulated and the apparatus tightened. This equipment was worn comfortably and without complication for two months and six days. The condition eight months after the injury, good union, good position and clinically 100% return of function.

The next case is a white man age 30 who when he jumped from a moving freight car sustained a compound comminuted fracture of the distal ends of the right tibia and fibula with marked displacement. The patient was given a general anesthesia, thorough cleansing with soap and water and saline irrigation, debridement of lacerated soft tissues, two pins were placed unparallel through the os calcis, two pins unparallel through the shaft of the tibia, the fragments manipulated and immobilized with long bars along side the leg as described in the previous cases. Tetanus and gas gangrene antitoxin was given. The wound of the soft tissues was loosely sutured. This case was before penicillin was available but sulfathiazole was given by mouth. The external fixation apparatus was worn comfortably and without complication for three and one-half months. There was no infection of the compound fracture or about the pins. Massage was instituted and carried on for several months. Six and one-half months of the fragments. Ten months after the injury, under general anesthesia a tenotomy of the Achilles tendon was done, the ankle joint manipulated, and a plaster boot cast applied with the foot at right angle to the leg. The cast was worn about a month. When last seen 13 months after the original injury the patient had 70 to 75% restoration of function of the ankle joint.

The next case is that of a 32 year old negro who while operating a tractor got his left leg crushed between a sharp metal edge of the tractor frame and the side of another tractor and sustained a severely compounded and comminuted fracture of the distal portion of the left tibia and fibula about two inches above the ankle joint with distortion of the fragments. Under general anesthesia the leg was thoroughly cleansed with soap and water and normal saline irrigations, the lacerated soft tissue debrided and external fixation apparatus applied. Two unparallel pins were placed in the shaft of the tibia, one pin placed transversely through the lower fragment of the tibia above the ankle joint and the second of the lower pair of pins placed transversely through the os calcis. The fragments were manipulated and immobilized with the long bars alongside the leg. The soft tissue wound was not sutured. Tetanus and gas bacillus antitoxin were given, also a course of penicillin intramuscularly. The external fixation apparatus was worn comfortably and without complication for a few days longer than two months. There was no infection of either the compound fracture or about the pins; but apparently due to the pin in the os calcis being not sufficiently unparallel to the pin in the lower end of the tibia it became loose and served no useful function. Four days after the removal of the pins a plaster cast was applied. This was worn for two months. Against our advice the patient began weight bearing and an outward angulation of the lower fragments resulted. Under general anesthesia correction was made and another plaster cast applied. This cast was worn for a month. The patient was last seen ten months after the injury with bony union and position as shown in the last slide. Although there is slight eversion angulation of the distal fragments after the patient made a financial settlement with his employer he walked well with only a slight limp, said he was very well pleased with the results and clinically had a very comfortable and useful foot.

The next is a 61 year old elevator repairman weighing 260 pounds who fell 15 feet down an elevator shaft and sustained this markedly comminuted, badly compounded and displaced fracture just above and into the ankle joint. This patient was so fat and had just had lunch so morphine-Scopolamine

anesthesia was used. This was given in three doses 45 minutes apart and was the only anesthetic used. The skin of the leg was thoroughly washed with soap and water followed by saline irrigation, the compounding wound debrided and thoroughly irrigated with warm saline and the pins and clamps and bars applied as in the previous cases and a check-up x-ray study made. You will note that there is still a large tibia fragment displaced. A sterile gloved finger was inserted through the compounding soft tissue wound into the joint and the fragment manipulated into position. The compounding soft tissue wound was loosely closed with silk worm gut; the patient placed on a course of penicillin intramuscularly; he was also given tetanus and gas bacillus antitoxin. He wore the apparatus three and a half months very comfortably and without complication. He returned to work five months after the accident. The patient has continued working, is comfortable and has almost 100% return of function.

This next case is that of a machinist who fell 20 feet from a locomotive and sustained a compound comminuted fracture of the lower end of the tibia and fibula. Under general anesthesia the skin was thoroughly cleansed with soap and water, the soft tissue compounding wound debrided and irrigated with saline, the pins placed in the os calcis and shaft of the tibia, the fragments manipulated and the apparatus tightened. The compounding wound was closed, tetanus and gas bacillus antitoxin given, and penicillin intramuscularly started. The patient is still in the hospital, is comfortable and has had no elevation of temperature.

Currently in the hospital is another patient who had the same type of apparatus applied for a compound fracture of the shaft of the tibia.

I wish to stress particularly in the use of this external fixation equipment that meticulous care as to sterile technic should be observed. The skin in all the cases is thoroughly washed with soap and water, irrigated with saline and 70% alcohol applied. Dressings are applied loosely about the pins for the first few days and thereafter no dressings or applications are made. In removing the pins the adjacent skin is cleansed with soap and water and also the protruding portions of the

pins. The pins are then further treated with phenol and alcohol and dried. No anesthetic is given to remove the pins.

There have been no infections in the bone in the compound cases. There have been no infections in the soft parts or the bone about the pins; no sloughing of the skin about the pins and the soft parts have healed promptly after the pins were removed.

We feel that the uncomplicated course and the end result in these cases is sufficiently satisfactory to advocate that the judicious application with meticulous care of external fixation apparatus deserves a prominent place in the armamentarium and procedure of handling selected problems of severe fractures in and about the ankle joint.

PENICILLIN AND HORMONES GIVE NEW HOPE AGAINST RHEUMATIC FEVER

Use of penicillin in preventing rheumatic fever, and the experimental treatment of the disease with the hormones ACTH and cortisone, were described today as bringing "new hope for young hearts" in a leaflet entitled "What You Should Know about Rheumatic Fever," published by the American Heart Association and its affiliates. The leaflet is being distributed in conjunction with the 1951 Heart Fund Campaign conducted throughout February.

A primary objective of the Heart Fund is to help finance research in rheumatic fever and rheumatic heart disease, which have been termed "childhood's greatest enemy," and which account for a major share of all cardiovascular ills. Next to accidents, it was pointed out, these diseases kill or disable more school-age children than any other cause. They also affect adults, having immobilized 40,000 service men in World War II.

Early treatment of certain streptococcal nose and throat infections, which precede rheumatic fever, has been found to reduce initial attacks of the disease and has proved effective in preventing recurrences, the Heart Association leaflet states. When rheumatic fever does occur, promising and dramatic results have been obtained in the treatment of early cases with the hormones

(Continued on Page 48)

The Diagnostic Significance of Some Ocular Complaints

P. J. Leinfelder, M.D.*

Every complaint referable to the eyes is not indicative of ocular disease or a need for glasses, nor is every patient who complains of twitching of the lids, irritation of the conjunctiva, or fatigue from reading in need of eye treatments, for most frequently such complaints are the result of fatigue brought on by various and sundry complications in the high speed and high pressure life we lead. However, complaints of changes in the visual acuity, of headache associated with the eyes, or of double vision usually are indications for an ocular examination. Gradual failure in visual acuity frequently occurs without the patient being aware of any disease process or limitation of his vision. This is particularly true when gradual loss occurs in one eye, for with normal visual acuity in the remaining eye visual functions are not limited. Therefore it is always desirable to record the visual acuity on any patient who is being examined. Sudden loss of vision that results from vascular accidents involving the central retinal artery or vein are usually recognized at the time of occurrence.

If there is uncorrectible reduction in visual acuity in one eye or both eyes, it should be explainable by ophthalmoscopic examination or by means of visual field studies. Reduction in visual acuity may occur from purely ocular causes. The most frequent of these is refractive error. This is easily diagnosed since proper correcting lenses result in improvement to normal. There may be opacities in the cornea, lens or vitreous. Corneal scars which have occurred as the result of injuries or ulcers may reduce the vision considerably, but they are evident on inspection since the white haze in the cornea can easily be seen. Opacities in the lens constitute cataractous change that may be recognized on ophthalmoscopic examination with the pupil dilated. Finally, reduction in vision may be the re-

sult of inflammatory or degenerative disease within the eye itself. Iridocyclitis may reduce vision by forming adhesions and membranes over the pupil. Chorioretinitis may impair vision by destroying large areas of the retina. Glaucoma destroys vision because high intra-ocular pressure eventually causes atrophy of the optic nerve. These conditions, in most instances, produce changes in the appearance of the eyes that are easily recognized by the general practitioner as conditions that require the attention of the ophthalmologist.

A second cause for visual loss is the ocular change that may occur as a local manifestation of a general disease. These changes are ophthalmoscopically visible manifestations of involvement of the optic nerve in inflammation or degeneration, and affection of the arteries or of the retina in degenerative or thrombotic phenomena. Formerly syphilis was the primary disease responsible for these changes, and many patients were first diagnosed syphilis because of the ocular manifestations of this disease. Sometimes the external ocular signs of the disease (Argyll Robertson pupil, or extra-ocular muscle paralysis) were evident, but frequently it was optic atrophy, chorioretinitis, or papillitis. However, as the better therapeutic control of syphilis has been accomplished, optic atrophy and chorioretinitis have become less frequent in occurrence and less important as diagnostic signs.

Affection of the optic nerve occurs in other diseases in the form of retrobulbar neuritis. This disease, which is accompanied by gradual or sudden loss of visual acuity, may be the result of nutritional (Vitamin B¹) deficiency as in tobacco-alcohol amblyopia, or from specific poisoning (lead or aniline) or as a manifestation of multiple sclerosis.

Multiple sclerosis is suspected when loss of central vision occurs in one or both eyes of a young adult. This symptom, which is indicative of optic neuritis, may be the earliest as

* Department of Ophthalmology, College of Medicine, State University of Iowa.

well as the only evidence of the disease. Such a patient complains of the loss of central visual acuity, usually in one eye, which has been present in increasing degree for a period of several days, and which may progress to complete blindness. After a period of time improvement which may be complete or partial occurs. If improvement is partial, temporal atrophy of the nerve head results and we then see the sign so frequently mentioned as diagnostic of multiple sclerosis — temporal pallor of the optic nerve. Loss of visual acuity or visual fields may occur with brain tumors that encroach on the optic nerve, chiasm, optic tract, radiations or occipital cortex. In order to diagnose these conditions visual field examinations must be done on all patients with unexplained visual loss.

In hypertensive and arteriosclerotic vascular disease various changes in the vascular tree of the retina can be recognized ophthalmoscopically. Changes indicating slight, moderate or profound disease of the blood vessels may be correlated with the general state of the patient. In some instances localized occlusion of the arteries or veins of the retina result in loss of vision because of consequent degeneration of the retina.

In diabetes two types of change can occur which are of diagnostic importance. Cataractous changes in the lens may occur when the patient is careless about the control of the disease. Protracted high blood sugar injures the lens epithelium in such a way that months later opacities appear in the lens. Retinal changes occur in many diabetics, but usually only after the disease has been present for eight to ten years. When hemorrhages or degenerative areas occur in the macular region or venous thrombosis develops, visual acuity is markedly affected.

Finally, we have the changes in visual acuity that result from the retinal complications of general disease, such as occur in the retinopathies that are manifestation of advanced hypertensive vascular disease, arteriosclerosis, nephritis, leukemia and anemia. Visual loss is usually due to edema or hemorrhage in the macular region, and is proportionate to the extent of the retinopathy. The presence of these retinopathies is definitely a serious sign, although it is not necessarily an indication of early death. In older patients with hypertensive vascular disease,

no great significance can be placed upon the presence of retinal changes, but in the younger hypertensive patient the appearance of retinopathy indicates a poor prognosis. However, many of these patients will improve if treated by bed rest and the several methods that are available for improving the general condition.

The ophthalmologist is no better able to solve the problem of headaches than is any other practitioner of medicine. Although many of the ophthalmologists' patients complain of headache, the ocular causes for headache are few. Just as the complaint of headache is of little diagnostic importance in general medicine or neurology, it is of little significance in ophthalmology. Very infrequently is it an indication for a need of glasses, and on the rarest of occasions does it indicate primary ocular disease. It is most important as an indication of pituitary tumor and in those patients in whom headache has been a persistent complaint over a period of months or years and in whom treatment of various types has accomplished little in relief, visual field studies and ex-rays of the skull should be made for the purpose of ruling out pituitary disease. In other forms of brain tumor headache is inconstant, but if it occurs with choked disc, diagnosis of increased intracranial pressure is almost a certainty. Refractive errors and anomalies of the oculomotor system under the terminology of phorias are overworked as causes of headaches, which really are manifestations of fatigue states rather than ocular conditions.

Double vision is a most annoying complaint. The patient is severely troubled by the confusion that results when he sees two objects where there is only one. Not infrequently the doctor is also puzzled because it can be difficult to determine the type of motor involvement that is responsible for the trouble, and to locate the site of the lesion responsible for the paralysis. In former years the most frequent cause for involvement of the oculo-motor apparatus was syphilis and meningitis. In recent years utilization of new therapeutic measures has nearly eliminated these diseases as etiologic agents, and at the present time the most frequent cause for double vision is vascular disease. Older individuals suffer vascular accidents in the

(Continued on Page 47)



PRESIDENT'S PAGE

L. J. Pankow, M.D.

February Message

Voluntary Health and Hospital Insurance in South Dakota has enjoyed a rapid and healthy growth. A very tidy percentage of our population is now covered by some form of insurance to relieve the immediate burden of an unforeseen illness. There are however numerous expressions of dissatisfaction with Companies for rejection of claims and of refusals to renew policies in instances that seem completely unjustified to us. Without doubt many of the complaints expressed are true. Many features of voluntary

health insurance are not ideal, but even with its faults it is preferable to Ewingism at its best, and it behooves us to make voluntary insurance plans work so well that the other is not possible of introduction. A complaint heard from Insurance Carriers is that too many claims against them are neither just nor honest.

A sales point of hospital insurance is hospital-service features, such as x-rays, pathology and anesthetic service and the furnishing of drugs for the patient. These are perogatives of physicians and of pharmacies, but custom has included them in the hospital bill to be paid by the insurance company. Too often a patient is hospitalized for a laboratory work-up or for x-rays, because if he is a hospital patient he does not have to pay for these services, or for expensive drugs which he may take home with him. His insurance pays for these things. Still more unjust, actually dishonest, is the practice of some patients, aided and abetted by their doctor, to distort the history of their illness or to conceal the true diagnosis so as to bring themselves within insurance coverage. Doctors might be persuaded to lend themselves to such schemes for the purpose of collecting for service that might otherwise be near charity. Then great indignation and vilification follows by the sinner when the insurance company ferrets out the truth and refuses to be stuck by these fictions.

Insurance fiction may sometimes pay, but sometime it may collect, too. I quote from the South Dakota Code.

SDC 31.9931 False proofs of loss in insurance. Every person who presents or causes to be presented any false or fraudulent claim, or any proof in support of any such claim, upon any contract of insurance for the payment of any loss, or who prepares, makes, or subscribes any account, certificate, survey, affidavit, proof of loss, or other book, paper, or writing, with intent to present or use the same, or to allow it to be presented or used in support of any such claim, is punishable by imprisonment in the State Penitentiary not exceeding three years, or by a fine not exceeding one thousand dollars, or both.

Gentlemen and Ladies of my Profession, let us be honest with ourselves and with our friends, the Insurance Companies. They are working with us against the malignant forces advocating state controlled medicine. Let us not make ourselves liable to imprisonment and fine. Let us not furnish proof of the accusations of our enemies, the oscars and the harrys, that our profession is not to be trusted to enjoy the blessings of FREE ENTERPRISE.

EDITORIAL PAGE

MATERNAL DEATH RATE

If an authentic notice was put on the A. P. Wires that a man had run a hundred yards in five seconds, it would create quite a well worth lot of attention. So also, if someone had been found who could throw a sixteen pound shot eighty feet or more. But when, a few weeks ago in Time magazine, a small paragraph was given to the statement that for the first time the Obstetrical Death Rate in the United States had dropped below 1 per 1,000, it didn't seem that it caused enough amazement.

A few years ago when antibiotics were first discovered, the maternal death rate was about 6 per 1000. Even this was very good. At that time no one dreamed that the rate could be reduced to 1 per 1000. Then the antibiotics were discovered and put to use and the incredible low rate of 1 per 1000 has now been reached.

The research workers who developed the various antibiotics rightly deserve the greatest amount of credit and honor. But the wholesale application of the ideas and treatments belong to the physicians of the United States, both specialists and general practitioners. Without a doubt, this is the lowest maternal death rate in the world today, and it was accomplished under the present setup of medical practice. Oscar Ewing won't be using these data, nor will any of his speech writers. It is a great tribute to teamwork. Our team consists of the research workers, the specialist and the general practitioner. Neither one can get along without the other. Congratulations team.

J. A. Kittelson, M.D.

GULLIBLE'S TRAVELS

Gullible has had his travels curbed slightly by virtue of membership in the legislature but he had to get to Pierre so he drove there in the company of **D. B. Broderick** executive secretary of the Auto Dealers Association on New Year's Day.

Jan. 2 — Attended the first session of the House and that evening met everybody, including **Dr. Faris Pfister**, at the Reception and Inaugural Ball. Also ran into **Dr. Roscoe Dean** of Wessington Springs.

Jan. 3 — Was the guest of **Dr. I. R. Salliday** at Kiwanis Club at noon and then spent some time at **Karl Goldsmith's** office discussing medical legislation.

Jan. 5 — After the session Broderick and I left for Sioux Falls, weather clear, track fast most of the way.

Jan. 7 — Sunday — Drove with **Miss Sundstrom** of our office to Huron where we picked up **Dr. L. J. Pankow** at the airport, and then drove to Redfield for the first meeting of the Grievance Committee. We were home by 8:00 P. M.

Jan. 8 — Drove back to Pierre after adding over 800 miles on my speedometer over the weekend. I'm glad I'M in the legislature and not doing any traveling.

POLIO COURSES AVAILABLE SOON

The South Dakota State Medical Association has been notified by the National Foundation for Infantile Paralysis that a course in "Poliomyelitis-Team Approach to Total Care" is being offered in Los Angeles at the Orthopaedic Hospital, 2400 South Flower Street, in May and again in October. The course lasts five days and has a registration fee of \$5.00 and tuition fee of \$10.00 Physicians and nurses who need financial assistance to attend the course should make an early application for this from their local chapter of the National Foundation.

The course is designed to present all phases of patient care with emphasis on coordination of services and not for specific training for any specialty. Latest developments in respirator techniques and equipment, discussion of virology, pathology, diagnosis and care of the acute polio patient will be presented on

the first day through cooperation with the Los Angeles General Hospital.

The rest of the program will take in all phases of treatment of the sub-acute, convalescent and chronic patient.

For further information and application physicians should address C. L. Lowman, M.D., Director of Education and Rehabilitation, Orthopaedic Hospital.

(Continued from Page 44)

brain stem which cause destruction of or hemorrhage into the various portions of the oculo-motor nuclei. This results in either partial or complete ophthalmoplegia that is of sudden onset and which may occur without other signs of cerebral involvement. In some instances complete recovery may occur after several weeks or several months. The patient who has had such an episode becomes a likely candidate for further vascular accidents and the usual circumstances is that recurring strokes are encountered in succeeding years.

Brain tumors may result in paralysis of one or more of the extra-ocular muscles. Increased intracranial pressure can cause pressure on the 6th nerve in its long course over the base of the brain, and this then results in paralysis of one or both of the lateral rectus muscles. Lateral extension of a pituitary tumor may compress the 3d nerve. Tumors in the posterior fossa may cause paralysis of the various oculo-motor muscles because of pressure on or infiltration into the oculo-motor nuclei or their connecting pathways. In tumor of the pineal an early sign is paralysis of vertical gaze, which may be accompanied by paralysis of individual muscles supplied by the 3d nerve. In addition to brain tumor one must remember the possibility of aneurysm at the base. Since the most frequent site for this is in the posterior communicating artery, pressure on the oculo-motor nerves as well as on the optic tract and chiasm are probable.

Fleeting paralysis of the muscles supplied by the oculo-motor nerves may be caused by multiple sclerosis. The patient may complain of diplopia that may last for from a few hours to several days. This may be due to the paralysis of a single muscle or of several, but because of the inconstancy diagnosis of the involved muscle may be difficult. Less fre-

quent causes of paralysis of the extra-ocular muscles are meningitis, encephalitis, and syphilis. Since these conditions are primarily seen by the internist and since involvement of the extra-ocular muscles is a recognized sign of the diseases, they are seen more frequently by the general clinician than they are by the ophthalmologist.

Lifted from the Journal of:

NEBRASKA — The University of Nebraska College of Medicine through the MCH will offer a post-graduate course in Pediatrics and Obstetrics the last week in April. Registration will be limited to 25. Applications will be accepted in order as they are received. This will be a refresher course in the two subjects and the program will have eight guest speakers, four in Pediatrics and four in Obstetrics.

Dr. Lester D. Odell, Chairman of the Department of Obstetrics and Gynecology at the University of Nebraska College of Medicine, has received a \$2,900 grant from the Eli Lilly Research Laboratories. The money is to be used to carry on an investigation for the use of acid exchange resin for toxemia of pregnancy.

MINNESOTA — **Dr. Philip S. Hench** and **Dr. Edward C. Kendall**, both of Rochester, were presented with the Nobel Prize in medicine at ceremonies in Stockholm, Sweden, on December 10. The award was made by King Gustav VI.

The fifty-eight annual meeting of the Western Surgical Association was held in Minneapolis November 29 through December 2. Several hundred surgeons from throughout the nation watched operations in Minneapolis hospitals and attended clinics at Minneapolis General and Veterans Hospitals. A feature of the session was a group of reports on experimental work done by the University of Minnesota Department of Surgery. Forty scientific papers were presented during the meeting.

KENTUCKY — A virus research laboratory which will concentrate upon childhood infections has been established at the University of Louisville School of Medicine. Its completion was effected by a grant from the recently organized Kentucky Child Health

Foundation. The investigations will be supervised by Drs. Alex J. Steigman and James G. Shaffer of the school's Child Health and Bacteriology Departments.

JOURNAL—LANCET—The North Dakota State Health Department has established a new service which will determine quickly for the doctor what antibiotic will kill the organisms causing a problem case of illness. At present the laboratories have seven standard antibiotics to be used in checking the sensitivity of micro-organisms. This service, which is available to physicians and hospitals, is provided by the public health laboratories in Bismarck and Grand Forks.

CALIFORNIA — Physicians wishing to refer patients with hemophilia or allied abnormalities of blood coagulation for special study, without charge, by members of the faculty of Stanford University School of Medicine, may do so as a result of an anonymous gift of \$8,000 per year for three years to the university for research on the disease. Investigations into the fundamental nature of the coagulation defect are being conducted, and it is planned to study methods of therapy, including the effect of fractions of plasma protein on the course of nemophilia. Physicians who wish to refer patients should contact the office of the dean of the medical school in San Francisco.

Last year the amount of free mail sent out by the Government Printing Office at the expense of the taxpayers, much of it destined for wastebaskets, cost \$75,000,000 . . . Included in the collection of pamphlets issued by the Government Printing Office in the past ten years are the following fascinating titles: "Methods of Catching and Killing Vagrant Cats"; "Fleas of North America"; "How to Tell the Sex of a Watermelon"; "Mist Netting for Birds in Japan"; "Habits, Food and Economic Status of the Band-Tailed Pigeon."

Hey! That's OUR money they're using. All we have to do is to earn it so's we can pay the income tax — Simple, isn't it?

(Continued from Page 42)

ACTH and cortisone. As a result, the American Council on Rheumatic Fever of the American Heart Association recently inaugurated a cooperative study of the effectiveness of the hormones in treating the disease.

Because of these recent medical advances, the rheumatic fever leaflet states, "Better methods of care and prevention today bring new hope for young hearts. Knowing the facts about these disease can spare you needless worry over your child's health."

With the caution that "recognizing and treating the disease is a job for experts; avoid fear and guesswork by seeing your doctor," the leaflet presents such facts as these:

What is Rheumatic Fever? Rheumatic fever is a disease that may affect any part of the body — particularly the heart, joints, blood vessels, skin or brain. Damage to the heart may be fatal or long-lasting, but the effects on other parts of the body are usually temporary and not serious.

What is Rheumatic Heart Disease? Rheumatic heart disease is the inflammation and scarring of the heart muscle and heart valves as a result of rheumatic fever. This may interfere with the work of the vital "pump" that supplies the blood our bodies need.

Does rheumatic fever always damage the heart for life? No. Two out of three rheumatic fever get well completely or have so little heart damage they can work or play like anyone else.

What causes rheumatic fever? The immediate cause is unknown. When rheumatic fever strikes, it usually follows nose and throat infections that are caused by a germ of the streptococcus family. For example, "strep" sore throat, tonsillitis, or scarlet fever.

Prescribe

Journal

Advertised

Products

This is



FEBRUARY
1951
Vol. 4 No. 2

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Board of Obstetrics and Gynecology Adopt Changes in Regulations

At a special meeting of the American Board of Obstetrics and Gynecology, held in Pittsburgh, Pennsylvania, December 14, 1950, the following changes in the regulations of the Board were unanimously adopted:

1. That physicians otherwise qualified, who were graduated before January 1, 1939 and whose required training was in obstetrics or gynecology alone, and who have confined their practice to obstetrics or gynecology for at least five (5) years immediately prior to application be accepted for examination as candidates for certification in either obstetrics or gynecology. In all other respects requirements for eligibility remain the same for those physicians graduated since 1939. Bilateral training is required as published in the Bulletin of the Board.

2. Applicants who have been certified by one of the other American Specialty Examining Boards will not be eligible for certification by this Board until they have relinquished the certificate previously conferred.

3. Since the vast majority of obstetrical and gynecological cases are non-operative the Board requires adequate training in basic sciences, infertility, endocrinology, oncology, irradiation therapy, psychosomatic medicine, electrotherapy, and other non-operative methods of diagnosis and treatment as well as training in major operative procedures.

35 OFFICERS ATTEND ANNUAL CONFERENCE

Thirty-five district officers and councillors attended the 3rd Annual Conference of Councillors and Officers of the South Dakota State Medical Association in Huron, Sunday, January 14.

The program consisted of discussions of problems which are currently of interest to the district societies. R. G. Mayer, M.D., Secretary of the State Medical Association led a discussion on District Society Activities. John C. Foster, Secretary of the Advisory Committee to Selective Service, led a discussion on the Doctor Draft. L. J. Pankow, M.D., Sioux Falls, President of the State

Medical Association, gave a talk on the Grievance Committee.

GENERAL MOTORS ANNOUNCES RESEARCH PROJECT

The General Motors Company on December 19th announced a \$1,500,000 research project to promote better health for its 446,000 employees as well as the men and women of all American industry.

In conjunction with the University of Michigan they have established The Institute of Industrial Health at Ann Arbor, Michigan, whose broad objectives will be research, education and service in Industrial medicine, health and safety.

The project will be administered by a Board to be appointed by the University of Michigan Regents. Findings of the Institute in its wide range of research activities including the prevention, diagnoses and treatment of occupational diseases, will be made available to all companies and all employees of American industry.

MEDICAL STUDENTS ORGANIZE ASS'N

An academic society of the American Medical Association will be organized at the

University of South Dakota shortly by **Dave Buchanan**, second year med. student, son of **Dr. R. A. Buchanan**, of Huron. Buchanan was elected treasurer of the newly formed national Student American Medical association at the organizational convention in Chicago last month.

Buchanan took his undergraduate work at Huron college and is a member of the Coop board of control at the University. He was elected delegate to the Chicago convention by a vote of the University medical students.

The convention of delegates ratified a national constitution and made arrangements to hold an executive council meeting during the month of February. Treasurer Buchanan will attend the February meeting.

Objectives of the national organization are the advancement of medicine, contribution to the welfare and education of medical students, familiarization of its members with the purposes and ideals of the medical profession and the preparation of its members to meet the social, moral and ethical obligations of the profession.

THIRD DISTRICT HEARS SMORSZCZOK

The Third District Medical Society met Thursday, February 8 at the Tea Room of the Flandreau Indian School to hear **Dr. Smorszczok** of Monticello, Minnesota speak on his experiences as a practitioner of medicine while behind the iron curtain in Poland. **Dr. Boyd** of **Flandreau** was in charge of arrangements.

NEWS NOTES

Dr. Charles Tesar, recently of Detroit, Michigan, has set up practice at Midland, South Dakota.

R. L. Livingston, M.D., Yankton, has returned there from Kansas University where he completed his specialty in Urology.

Guy Van Demark, M.D., Chairman of the Advisory Committee to Selective Service for the State of South Dakota, attended a meeting of state representatives on Selective Service in Washington, February 11 and 12.

Dr. F. M. Newman of Presho died recently.

TRIPP LIONS CLUB PLANS MEDICAL CLINIC

The Tripp Lions Club decided at a recent meeting to make this year's project the building of a medical clinic in Tripp. **William Hoff**, president of the Club, stated that a clinic to take care of routine and emergency medical care was one of the town's greatest needs. A fund raising program was set to start February 12.

SIoux FALLS DOCTOR WINS COSMO AWARD

Dr. Guy E. Van Demark, Sioux Falls, was presented with the Distinguished Service Award of the Sioux Falls Cosmopolitan Club at their 27th annual banquet at the Cataract Hotel.

Dr. Van Demark was given the award for his service to crippled children. He has been a state supervisor in children's work and conducts clinics throughout the state on their behalf. He has been

active in the planning for the Crippled Children's Hospital and School in Sioux Falls.

MIDWEST MEET DRAWS FORTY

Nearly forty district presidents, secretaries, and councillors attended the third annual midwinter meeting in Huron, Sunday, January 14.

The group heard discussions by **R. G. Mayer, M.D.**, **L. J. Pankow, M.D.**, **M. M. Morrissey, M.D.**, **G. J. Van Heuvelen, M.D.** and **J. C. Foster**. Their subjects were "Operation of the District Society", "Grievance Committee", "State Legislation", "The State Department of Health" and "The Doctor Draft".

The afternoon session was devoted to a council meeting which discussed proposed legislation and various other matters.

GP ACADEMY MEETS ELECTS OFFICERS

The South Dakota Chapter of the American Academy of General Practice met in Huron Saturday evening, January 13 to discuss plans for the future.

Officers elected were:

F. F. Pfister, M.D., Webster — President

A. P. Reding, M.D., Marion — Vice-President

J. A. Kittelson, M.D., Sioux Falls — Secretary-Treasurer

Drs. J. A. Kittelson and **L. J. Pankow** were named delegates to the national convention which will be held in San Francisco in March. Alternates were: **F. F. Pfister, M.D.** and **A. P. Peeke, M.D.** A large attendance turned out for a lively meeting and interesting program.

WANTED

Female X-Ray Technician
Certified

For My Office

Paul V. McCarthy, M.D.
527 Citizen Bank Bldg.
Aberdeen, S. Dak.

**HOSPITAL - ACCIDENT - SICKNESS
INSURANCE**

FOR PHYSICIANS, SURGEONS, DENTISTS EXCLUSIVELY



\$5,000.00 accidental death	\$8.00
\$25.00 weekly indemnity, accident and sickness	Quarterly
\$10,000.00 accidental death	\$16.00
\$50.00 weekly indemnity, accident and sickness	Quarterly
\$15,000.00 accidental death	\$24.00
\$75.00 weekly indemnity, accident and sickness	Quarterly
\$20,000.00 accidental death	\$32.00
\$100.00 weekly indemnity, accident and sickness	Quarterly
ALSO HOSPITAL POLICIES FOR MEMBERS WIVES AND CHILDREN AT SMALL ADDITIONAL COST	

85c out of each \$1.00 gross income used
for members' benefits

\$4,000,000.00	\$17,000,000.00
INVESTED ASSETS	PAID FOR CLAIMS
\$200,000.00 deposited with State of Nebraska for protection of our members	
Disability need not be incurred in line of duty—benefits from the beginning day of disability	
PHYSICIANS CASUALTY ASSOCIATION PHYSICIANS HEALTH ASSOCIATION 49 years under the same management 400 FIRST NATIONAL BANK BLDG., OMAHA 2, NEBRASKA	

Refresh...add zest
to the hour



PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor

"REPORT ON THE FINANCIAL AND PHYSICAL LAYOUT OF A DRUG STORE"

by Claude L. Smith, McKesson and Robbins, Inc.

Mr. President, Ladies and Gentlemen of the South Dakota Pharmaceutical Association:

I recognize the fact that we are running late, and I am going to streamline my talk. I will ask you to bear with me, as I was going to speak in a subtle way and I had some stories — incidentally they were all clean stories — but I will have to use the direct approach and take a chance with having you disagree with me.

I do not know if you appreciate the spot I am in, the only wholesaler here between two hot shot manufacturers. It is a rather embarrassing position to be in. I have been on programs with them before so I am sure they will be a little bit tolerant and lenient with me.

I have attended a number of conventions, and I have tried to analyze why a retail druggist goes to conventions. I think there are four facts. First, I think he wants to get away from his store and have a little vacation. You certainly cannot hate him for that. Second, we want to meet and fraternize with his old pals, or school chums. Third, he wishes to get caught up on the best current stories. But, most of all, he hopes that a speaker will come along with maybe a thought he can carry back to his store and apply to his operation, and perhaps be a little bit better operator than he was before.

In planning a talk before a group of this kind, it is very easy to resort to flattery; and you go home with the feeling that Mr. So and So certainly made a good talk, but when your clerk asks you what Mr. So and So said, you answer him, "I don't know, but he certainly made a good talk." That is not the kind of a talk I am going to give. I am going to take a chance on putting some barbs into this and let the chips fall where they may.

I am going to ask you to bear with me for just a minute to give you a little personal background to qualify. I know you are not interested in my background personally, but I want to give it to you to qualify some of the statements I am going to make. I traveled on the road for a wholesale drug house in 1910. I have been traveling for forty years. I have called on every size, shape, form of an operation. My first territory was covered in the summer time with a horse and buggy, and with a sleigh in the winter. When I say I called on small stores, I defy a man to get up here who is doing the volume that the large majority of my accounts did at that time. Since that time I have called on other type operations, up to the finest stores, including chains. I only say this to qualify some of the remarks I am going to make.

One of the things I want to impress upon you very strongly is that I am sold on pharmacy, and I am sold on the drug business. Many times in giving a talk hurriedly, people misinterpret some of the things I say, and they say he is sold on a lot of these other departments, but he doesn't think much of the drug end of it. I like the drug business, I have been in it forty years, and it has been very good to me. I have a son in college and when he graduates, if he has the ability to pass the aptitude tests that are required, I want him in the drug business. There is nothing that hurts me anymore than to get into a retail store and have a pharmacist say, "I would rather see my son dead rather than take up pharmacy." Another point I want to make clear is that I am strictly sold on the drug end of the drug business. That is a very selfish angle because the profit of the wholesale druggist lies in the pharmaceutical end of the business. It is the greatest end of our business. I want to clear those two points so you will not misinterpret some of the things I am going to say.

* An Address as delivered before the Annual Convention of the South Dakota State Pharmaceutical Association in Sioux Falls on June 14, 1950.

I am going to talk about magazines, cigarettes, candy, soda fountains; and I am going to talk about book-keeping systems. I have nothing to sell in any one of those five phases. We do not print magazines; we do not handle tobacco in the large majority of our houses; we do very little candy business; we do not make ice-cream; and we do not prepare a bookkeeping system, but, I have heard it expressed here, and you have repeatedly, that it is imperative that we become economists if we are going to stay in the drug business. The drug business is a three billion, six hundred million, dollar business. It is a Frankenstein. We can clown, and we can talk all about these other allied lines, but it is something that the drug business has built up and we have to recognize it. We must place in these stores the departments where we get the greatest yield, despite the fact that fifty-three percent of the volume in the average drug store is drug business.

We have had four serious set backs or depressions in the last forty year. We had one in 1915, when the politicians could not make up their minds whether we were going to get into World War I or not, and if we did get into it, which side we were going to fight on. The stock market crashed in 1915 and business went to pot. It affected the drug business vitally. In 1921 we had another depression, and it was not on disposable income, manufacturing plants operated but they got caught in an inventory squeeze. A lot of GI's came out of World War I, the same as they did in World War II. They had a little capital and went into business. They opened electric appliance shops, grocery stores, and other types of business'. The drug business didn't suffer as much, and one of the reasons was because prices in World War I did not go up. We pride ourselves that we have held the line in World War II as far as drugs are concerned. Dunn and Bradstreet puts out a pamphlet, which they will be glad to send you for the asking, and which will show you that there was a greater mortality of small businesses in 1921 in proportion to the number of retail outlets than in the entire depressions of the thirties. In October 1929, the stock crash came. We recovered a little in November and then the trend went down. My good friend Landsdowne follows me, and I know he is going to refer to the Lilly Digest. I didn't

know he was going to be on this program until I got here, but I have to refer to the Lilly Digest because we use it so much in our business. The Lilly Digest will show you that back at this time the average gross profit in the average store was six thousand dollars, and in 1933 it was fourteen thousand dollars. That meant there was less than four thousand dollars for you to operate your store on and have a living. That was serious. We are coming into a squeeze of that kind right now, and the large majority of druggists are not conscious of it.

I told you I was going to refer to a book-keeping system (if any of you should like a copy of the following information, I will be glad to send it to you.) I had the opportunity to review the recap of two hundred and fifty drug stores in one city and one hundred and thirty-seven in another city. I do not know their names, I don't want to know their names. I do have them by account numbers. This was prepared by a company in Cleveland, the Line a Day Bookkeeping Company. Here are two exhibits, showing two drug stores that did one hundred and sixty-eight thousand dollars worth of business last year. They have practically the same square footage, and practically the same lineal feet. One of the stores made fifteen thousand dollars and the other made twenty-two thousand dollars. The next exhibit shows four drug stores doing approximately sixty thousand dollars. The first store made six thousand; the "B" store made three thousand, two hundred dollars; the "C" store made twenty-eight hundred dollars, and the "D" store lost sixty dollars. I have a recap here of ten stores, and I would be glad, after I am through talking, to have you review it. Another exhibit I have shows a store in the southern part of the state of Ohio that did two hundred and twenty thousand dollars last year, a partnership, and they wound up with fourteen hundred net profit — that was before any owner salary was taken out. Needless to say they have a problem. There are two factors why that happened. Number one — the type of merchandise that was sold in the store. I wish that every drug store was a professional drug store because that would solve our problem, but that is wishful thinking. We have to talk about the situation as it actually exists. You have both the normal

gross and the high gross in these departments. I am reluctant in mentioning Economics after two of the talkers made a wonderful talk this morning; and it was wonderful to hear Dr. Serles talk about incorporating accounting and marketing in the curriculum of the school of pharmacy — that is something I have been set on for a number of years and it was very, very gratifying to hear him say that. We do have to become economic conscious. Your whole profit is predicated and based on your turn-over.

If you are in the jewelry business, you have to get one hundred percent, or a fifty percent mark-up because you have to double your money in the jewelry business as you have only one turn-over a year. In a drug store you get more turns a year so the basic economics was thirty-three and one third percent twenty-five or thirty years ago, and we have reason to believe that it will be thirty-three and one third percent twenty-five years hence. If you are in the grocery business, you could operate on as low as a ten to twelve percent mark-up because of the turn-over.

Another main item of expense is clerk hire. That is where a store often gets into difficulty. If you will refer to the Lilly Digest, or other authoritative sources for drug store economics, it will show you that clerk hire has sixteen and one half percent. In this exhibit you find that the proprietor has ten percent and the clerk has six and one half percent. The following year the proprietor has shrunk to nine and one half percent, and the clerk has gone to seven percent. Every year shows a gradual change, the percent going to the clerk becoming higher, and we have every reason to believe it is going to stay that way or get worse.

If you start out with sixteen and one half percent for clerk hire; three and two tenths for rent; you are crowding twenty percent for overhead. Then you have your heat, light, taxes, etc., which runs it up to twenty-five or twenty-six percent. Your net profit then is the spread between this twenty-five or twenty-six percent up to thirty-three and one third percent. There are lots and lots of stores, I hope your store is an exception, that are not conscious of this increase in personnel cost.

Referring back to the store, I mentioned a few minutes ago, that did over twenty-two

thousand dollars, they have a clerk hire cost of twenty-two percent. This twenty-two percent does not include the proprietor's salary. If you will pardon reference to my own company, our Cincinnati manager was called in to help them. They never realized what the trouble was until they reviewed the financial statement. The point I am trying to bring out is that we have to become economic conscious. We must know bookkeeping, and if we don't, we should hire the best that we can. Too often a store will call in a local man to make their financial statement. He does not know anything about the economics of the drug business itself; and he is unable to point out the weak points for you. I would recommend that you hire someone (and I can give you the names of a half dozen, or more) that can tell you if you have pilfering in your store; whether you are over-buying or under-buying; whether you are doing too much in certain departments with a low gross, and not enough in other departments with a high gross.

I am going to take an average drug store in a metropolitan area, which is twenty feet wide and sixty-five feet long, no chimneys, stairways or breaks. It is just as elementary to lay it out as ABC. We preach this to our men. We deal with a number of national dealers of store fixtures, and anytime anyone of them comes up with something new, we copy it. During my talk I have referred to chains and I will refer to chains. I am not carrying the torch for chains, but we do business with chains and we hope to do more business. There are forty nine thousand, four hundred and six drug stores in the United States. Last year there were six thousand, five hundred drug stores in the United States that averaged fifty-five dollars a day; there were six thousand, three hundred drug stores that averaged eighty-five dollars a day; there were sixteen thousand drug stores in the United States that averaged one hundred and fifty dollars a day. Those twenty-six thousand drug stores are our life's blood, and they are the ones that support us — so if I refer to chain drug stores, I am referring to them because they are successful operators. Whenever I see one of them put in a type of a unit, and it proves successful, I have no hesitancy at all in asking any one of the companies we do business with, to copy it, because I know

it has been tested, and I know there isn't anything that will get you into trouble more than in trying to experiment in your store.

I am going to talk about this average drug store that has a center entrance, no chimneys, stairways, or breaks. We recommend very strongly that the merchandizing is done down the right hand side of the store. You walk to the right, you drive to the right, your reflexes are faster from the right; and it is easier to see a display, contrary to your belief — or maybe you haven't given it any thought — than they are from the left. So, smart store lay-out people take advantage of all the idiosyncrasies of people. Now, if you have a stairway going up to apartments above, you have to reverse the store. It won't make or break the store, but it is going to be a little bit harder to maintain the same sales level in there as it is in the store where the merchandizing can be down the right hand side. I was amused at the Dean saying this morning to put your papers in the back of your store. We have tried some of these things. We have taken the tobacco department and put it in the middle of the store, we have put it in the back of the store, and neither of the plans worked. I am going to say something now that you are not going to like me for, but it is true. We in the drug business have pirated everything but the medicinal end of the business from other businesses. Think back to not many years ago when there was one store that had the magazines and newspapers, and everyone went to that one store to get them. Today it is very unusual to get into a town with that type of an operation. The drug stores have absorbed that business. Not too many years ago it wasn't uncommon to have three or four wooden Indians out in one block, signifying a tobacco store. We have pirated the tobacco business. We have taken the candy business from the confectionary stores. We have taken the ice-cream from the confectionary store. We have taken the lunch business from the restaurants. We have taken some cosmetic business — and that is debatable. It is just like the chicken and the egg, which came first. We have taken the cutlery business from the hardware stores. We have taken the clock and watch business from the jewelry store. But, there are two things that we have to do when we take the business — we have to accept the economics

of the business because we would price ourselves out on some of these low grosses if we tried to get thirty-three and one third percent, which we have to maintain as a retail drug operator. We also have to accept the method in which the people have been educated to buy this merchandise. The tobacco stores did a good job. They advertised that you never took more than three steps inside the store before you got to the first counter. Now, I have no axe to grind — if we could put one of these departments back in the store to pull the people through — fine.

I am going to try and reconstruct the left hand side of the drug store. We recommend that the first department inside the store with a center entrance should be the magazine department. There are pars in each one of these departments; and it is just as important that you know the pars here as it is in a game of golf. If you are going to run a drug store scientifically, you should know the pars of each department. You are not going to agree with some of these pars, and if you don't agree it is because you dramatize a particular department. The way to change it is not to reduce the sales in that department, but take the same dramatization into the other seven departments and increase the sales.

As I said, the first department is the magazine department and its 3.2 of your volume, and its a 15.5 gross. We start out in the very first department with something below our average profit of thirty-three and one third percent. It is a hazardous department. The pilferage is probably greater in the magazine department than in any other department in the store. There is a number of reasons for it. Many stores have blind spots that are difficult to see. Youngsters will come in and take magazines or the comics, even adults will do this. They are caught constantly in metropolitan areas of coming in, buying a Life and having an Esquire on the inside. That is one weak point. The second weak point, and please get me straight on this. I do not say that News Agencies are crooked, but I do say that in many large metropolitan areas there are boys who work on a commission basis and I would recommend very strongly that you have a good control of the turnover. On the pilferage end there are different reasons why people steal — whether it is in the magazine department or any place

else in the store. If a person is hungry, or if they are broke, they will take a chance on stealing. But, the large number of thefts are made by opportunity. You relieve that opportunity and you will cut down on your pilferage, so I strongly recommend that this department be visible from all parts of the store.

The next department is the tobacco department, another low gross, 18.28 is your par on that. You cannot gross more than fourteen percent on your tobacco department; and the large number of stores gross ten percent or less. Consequently, here we are with twenty-two percent of our over all business, starting out with less than a sixteen percent gross. You don't have to be much of a mathematician to know that you are going to have to have departments that will bring you in over thirty-three and one third percent if you are going to level off at thirty-three and one third percent.

The next department is candy, 5.5 is your par on that and the business is thirty-three and one third percent. You cannot get hurt on that department, so if you have the space, I strongly recommend mechanical refrigeration.

The next department is the soda fountain. Many successful chains have built their entire business around the soda fountain. It is a high gross, very profitable. The thing you have to keep in mind is that you cannot devote anymore lineal feet than twenty-six percent to this department because that is par. It creates foot traffic. Surveys show that the soda fountain contributes ten and seven tenths percent of your foot traffic in the store.

Now we go to the other side of the store where we have cosmetics. Cosmetics is very important. It represents nine and five tenths of the volume and you average thirty-three and one third percent.

The next department is the sundry department. This is the department we had so much trouble with during the war. It is only a five and four tenths percent of your business.

Following the sundry department, we have the proprietary section. This department offers the greatest possibility of exploitation possible, and it will change your gross profit picture. There is a big opportunity in the proprietary section for intelligent selling. I

might say that selling has reached a very low ebb, not only in independent stores, but in chains as well. The average sale in the independent store today is one dollar and six cents, and in the chain it is one dollar and eight cents. One thing the chain store is doing is conducting a very aggressive campaign of clerk education in this department. The par in this department is twenty three and two tenths percent.

We are the last people in the world that should talk about legislation in protecting our business. As I told you we have pirated everything but the medicinal end of the drug business from other businesses. If we ever started anything, there is no reason why these other businesses should not demand protection of their own; and believe me the loss that the drug store would face by fifty-four items would amount to a great deal.

Then we have the prescription department. That is the key note and the important department in the store; and again the destiny of your store lies within your hands. You have eight and three tenths percent in your prescription department, that is only the compounded prescriptions. If we included pharmaceutical specialties, the department goes up to fourteen, sixteen, or eighteen percent of the volume.

In this center entrance store, your confectionary side, your low grosses, are down one side of the store where your inexpensive help can handle it. In other words, the people at your fountain can take care of candy sales, cigar sales, and magazine sales. Down the right hand side; your cosmetician, your registered pharmacist, can take care of your high grosses. If you are on the northeast corner, then your merchandizing side is down the right hand side, and your fountain is down the left hand side.

When a customer enters a store, he should walk into live merchandise. I can take you into hundreds, I can take you into thousands, particularly in the metropolitan areas, where you enter a corner drug store and immediately run into the soda fountain with a wrapping counter right along side of it. Following this plan you will do eighty-five percent of your dollar volume over on this one side of your store through impulse buying. The reason for this is that people follow

(Continued on Page 58)

AUXILIARY ACTIVITIES

As we start a new year, it holds a great challenge to all of us. No doubt, 1951 will mean many changes in many of our lives, that will require great fortitude and sacrifice. May we rise and square our shoulders, to be able to accept our responsibilities as good citizens, and trust that it is for the best!

As auxiliary members, we can do a great deal, by participating in the general Health Education Programs that are being sponsored in our own communities. Be active in these projects, and see that the material presented is unbiased and authentic. There is a vast amount of material, movies and written literature, which is available to be used for such programs. A list of these films and any other desired information is available from me (Mrs. A. P. Reding, Marion) or from the South Dakota Medical Association Office in Sioux Falls. The address is 300 First National Bank Building. Do take advantage of this excellent source of information for the health programs at the local PTA, your Study Club, your church group, your Extension Club etc. There are films, on almost any health subject, which are interesting and authentic.

With the development of the Civilian Defense Program throughout the country, there is another opportunity for us to help. For instance, cooperate with the local chapter of the American Red Cross when they launch their extensive program for training civilians in First Aid and Home Nursing Courses. If you are a Registered Nurse you would be qualified to teach Home Nursing, why not volunteer your services? Civilians who have had proper instruction will be of great help in case of an emergency following a major disaster.

EXECUTIVE BOARD MEETS

Our first Executive Board Meeting was held in Sioux Falls on November 29th. After having lunch together at the Town Club, we went to the home of Mrs. V. V. Volin for our meeting.

Officers present for the Executive Board Meeting were:

Mrs. A. P. Reding, Pres., Marion

Mrs. Howard Wold, Pres.-elect, Madison

Mrs. V. V. Volin, Corr. Sec'y and Treas.,
Sioux Falls

Mrs. E. R. Schwartz, Recording Sec'y,
Wakonda

Mrs. Wm. Sercl, Past Pres.-Historian, Sioux
Falls

The main topic of discussion was the proposed NEWSLETTER which we hoped to get published before the holidays. Similar letters from other states were examined and discussed. It was decided that we should try to get out a simple, clearly mimeographed, letter to all doctor's wives in South Dakota as soon as possible. We will try to bring to mind the purpose of the Woman's Auxiliary, the obligations and the responsibilities of a doctor's wife, and why she should be an active auxiliary member. There will be messages from the Officers and the State Chairman.

We consulted John Foster, Executive Secretary of the S. D. Medical Association, about helping with our NEWSLETTER. Mr. Foster said that the office personnel would do the mimeographing and the mailing for us. We are to furnish the paper, envelopes and pay the postage.

Suppose you have wondered what became of the NEWSLETTER. We are going to get at it within the next few days and should get it together and in to your office by the fifteenth. Hope the girls will be able to take care of it for us about that time.

ABOUT THE NEWSLETTER

After careful thought and the short time we had to get our material assembled, we decided that the NEWSLETTER should not be sent out in the mad rush of the holiday mail. So before you receive this Journal, I'm sure that you will have had our first NEWSLETTER. We do hope to get one and possibly two more out before our State Convention in June.

PRESIDENT VISITS SIXTH DISTRICT

On December 4th, your president was invited to visit District Six at Mitchell. Tho the night was cold and snowy there was a nice crowd to enjoy the delicious three-course dinner. Holiday decorations added much and made it a festive affair.

Following the dinner, the district president, Mrs. Wm. Fritz introduced your president. I gave a brief report on the recent Conference in Chicago, which your president-elect, Mrs. Howard Wold and I attended. In order to follow the extensive program set up by the National Auxiliary, we will have to become more unified in our procedures. Other suggestions made were that the Auxiliary pledge be used to open each meeting, and that some short discussion periods be held at each meeting. These should include Auxiliary policies or projects, or other timely subjects on Public Relations or Legislation.

Each member was asked to see that Today's Health, AMA's official magazine, is in her husband's office and that each member should either sell or give as a gift at least one other subscription. I'm sure that District Six will make a good showing in this project.

Thank you District Six for a very enjoyable evening and especially for the lovely corsage.

Mrs. A. P. Reding,
State President.

(Continued from Page 55)

people. Nothing will attract people like people, and when you go into this type of a lay-out you have action around your soda fountain and you have action behind your wrapping counter. When you go home, look at your wrapping counter. You should have an eighteen foot wrapping counter, it is one of the best departments in your store, it creates a large flow of traffic.

People follow people. That is the reason why we recommend visual fronts. There are three things imperative in your visual front drug store. You must have a traffic location

because again I say people attract people, and if you haven't traffic in there, they will stay out. Second, you must have it well lighted, and third, you must have an immaculate store. A visual front will do much more for you than a window front.

I have talked a lot about clerk training, and if you will permit I would like to put in a plug here. We are offering a series of clerk training schools. We have obtained a Doctor from the University of Wisconsin to conduct these schools. He is a salesmanship and marketing expert. We are going to hold one school in St. Paul on July 31 and August 1; in Minneapolis on August 3 and 4; Sioux City, August 7 and 8; and in Omaha on August 10 and 11. I recommend these training courses with no reservation. You owe it to yourself to send as many from your store as you can. The only thing we ask is that a person be sincere in their wish to attend one of our schools. If he is not, we would rather that he didn't come. Again I repeat, I assure you it would be well worth your while.

Thank you.

NEWS NOTES

The Executive Committee of the Pharmaceutical Association and the Board of Pharmacy met at Pierre, S. D. on January 21 to discuss legislative and other affairs.

The only bill sponsored this session was to raise the poisonlicense fee from \$1 to \$3 per year.

The date for the annual convention has been set for June 13, 14 and 15th at Watertown. **Loran F. Thomes** has been named local chairman for the convention.

The Board approved the remission of the annual renewal fee for pharmacists on active duty in the Armed Forces.

Thomas Mills is now at the Van De Walle Pharmacy, Sioux Falls.

Dale Auchampach is now at Casey Drug, Chamberlain, S. D.



ROUGH HANDS FROM TOO MUCH SCRUBBING?

Soothe rough, dry skin with AR-EX Chap Cream. Contains healing ingredient, carbonyl diamide. Aids severely chapped and broken skin. Pleasant to use. Scented or Unscented. Send for sample.

AR-EX COSMETICS, INC., 1036-J W. Van Buren St., Chicago 7, Ill.

Treatment of Convalescent Poliomyelitis*

Earl C. Elkins, M.D., Section on Physical Medicine,
Mayo Clinic, Rochester, Minnesota

It should be clearly understood that there is no completely satisfactory treatment of poliomyelitis, *per se*. The major portion of the after-treatment of poliomyelitis is that done to salvage what remains of the function of the weak and paralyzed muscles, and to train or reconstruct the involved parts to the point where the patient obtains the best possible function of what he has left. Treatments such as supportive, physical and orthopedic, have no effect on the progress of the disease, once it has started, nor can such treatment change the already existing primary lesions of the central nervous system. Neither are there drugs which have any specific effect upon the disease. The use of immune serums has not yet met with any great success.

The concept of treatment of poliomyelitis is now fairly well established. However, the technics may vary. A simple, uniform program of treatment will not meet the needs of all patients who have poliomyelitis, because of the great variations of involvement in the disease.

There has been a considerable increase of interest in treatment of poliomyelitis during the past decade, because of the apparent increase in the incidence of the disease and the undoubted increase in accuracy of diagnosis. It is evident, however, that not enough physicians in widely scattered small hospitals are prepared to organize and supervise treatment for all phases of the disease. In many epidemic areas, where emergency technical help has been allocated, this personnel has been expected to examine patients and to evaluate and prescribe treatment for the neuromuscular involvement, in a large percentage of cases. Medical supervision often has been superficial and has consisted of irregular visits of a physician from a distant center.

Pathology

Time permits only a brief discussion of the pathology of this disease. However, consideration of a few salient points is essential.

It is well known that the virus of poliomyelitis produces localized inflammatory reactions in certain regions of the central nervous system. It is likewise well established that in every case of poliomyelitis there are lesions of the brain. It is important, however, to note that some parts of the brain are rarely, if ever, affected,^{*} and only a few centers are severely involved with sufficient frequency to suggest that their injury produces any symptoms. Experimentally, it is well established that distribution of lesions of poliomyelitis is due principally to two factors: (1) the variability in inherent resistance of the nerve centers to infection, which may be different in the tissue itself, and in different individuals; (2) the lesion may be dependent upon the movement of the virus along certain nerve fibers^{1, 2}.

Lesions of the cerebral cortex are rare, and if pathologic changes occur, they are found in the motor area and precentral gyrus. Even here, lesions are not sufficiently severe to produce clinical signs, except in rare instances.

The poliomyelitis virus may affect most of the centers of the brain stem, with the possible exception of the nuclei pontis and inferior olives. Sharp localization of lesions to a few functional centers was uncommon in one series^{1, 2}. The correlation of lesions in the brain stem with symptomatology must be largely speculative. In the series of 24 human cases mentioned previously, hardly any individual was found who did not have some involvement, sometimes to a severe degree. In most of them, the motor nuclei of the cranial nerves and the surrounding reticular formation were involved. However, clinical signs of paralysis controlled by the areas of the lesions were rarely recorded, except in the face, pharynx and larynx, in bulbar cases. Apparently there were enough remaining

* Read at the meeting of the South Dakota State Medical Association, Huron, South Dakota, May 22, 1950.

nerve cells in the oculomotor, motor trigeminal, and hypoglossal nuclei, to maintain adequate function in most cases. Extensive involvement of these centers does occur, and is evidenced by weakness of the muscles of the eye and face. The fact that the disease infrequently produces symptoms related to these nuclei illustrates the margin of safety from injury. However, minimal weakness in some of the cranial musculature may be overlooked^{1, 2}.

The great variability of involvement of the central nervous system in cases of poliomyelitis accounts for the fact that whereas paralysis is sometimes severe and permanent, there are cases in which it is mild and transitory. It should be noted that the lesions of the brain are widely scattered. In most instances, there are no symptoms as a result of lesions of the brain; however, it is difficult to believe that damage in the brain stem does not affect motor performance, even in mild paralytic cases.

It is assumed³ that recovery from lesions of the brain stem may result by two processes: (1) the recovery of the neurons not damaged sufficiently to be destroyed; and (2) the rerouting of the neuron discharge from the interrupted primary paths to the secondary alternative paths. The first process is considered to be completed in about a month; the second process is of longer duration, because it is brought about, in part, by retraining.⁴

Lesions of the spinal cord as a result of the poliomyelitis virus are fairly well known. Such lesions are the severest of the disease, and are always in the anterior columns. When the spinal cord is severely involved, the intermediate horns may be heavily damaged, and the posterior horns moderately affected. However, the damage here is more spotty in distribution than in the anterior horns. The posterior and intermediate columns are never completely destroyed, as are whole segments of the anterior columns. Likewise, it has been shown that the cell bodies which give rise to the internuncial nerve fibers are the most monnonly affected structures in the spinal cord.^{3, 5, 6}

If only a few motor cells in the spinal cord are involved, the muscles that they supply are not completely paralyzed. Such muscles may seem weak in the early stage of the

disease, but may undergo complete recovery. This recovery may take place within one to three months. The virus may invade the cells, and the cells may undergo some degeneration and then recover. Consequently, the functions of muscles supplied by them will return also. There is a stage in which recovery from paralysis is either exceedingly slow or absent, until treatment is started, although it may be months after the onset of the disease. In this instance, many of the motor cells may have been destroyed and many others involved, but not killed. The recovery of some function is undoubtedly due to reestablishment of the kinetic sense in the muscle, retaining in co-ordination, and finally hypertrophy of the remaining functioning muscle fibers to the point where they can take over adequate action of the part.

Tightness of muscle, which is often present in poliomyelitis, is not necessarily attributable to the lesions of the muscle itself. There is some evidence to indicate that it is a reflex phenomenon.^{7, 8} From a physiologic point of view, however, some find difficulty in accepting the explanation that tightness of muscle is on a reflex basis, as the reflex arcs may be involved in the disease process. Those who do not accept this explanation believe that a factor or structure in the muscle, perhaps fascia, is involved in the production of tightness. However, there is no good experimental evidence to substantiate this assumption.

The pathologic changes seen in the muscle and in the peripheral nerves cannot be attributed to the direct action of the virus. They can be attributed to the secondary changes resulting from the destruction of the anterior horn cells by the virus. Paralyzed muscles atrophy because of interference with circulation and because of loss of connection with the central nervous system. It is a recognized fact that once a muscle is completely disconnected from the central nervous system, it is bound to atrophy unless regeneration of the nerve cells occurs.

Clinical States of Poliomyelitis

The clinical course of poliomyelitis usually is divided into three stages. The acute phase is considered the febrile stage of the disease; the convalescent phase is considered that period beginning twenty-four to forty-eight hours after the patient becomes afebrile, and

lasting to the time when definitive treatment is stopped. The chronic stage begins when no further improvement is expected.

These stages cannot be compared to those occurring in a disease such as tuberculosis, in which the irritant continues to act for a long period. The extent of involvement in acute poliomyelitis is usually established within one to two weeks after the onset of the disease. It is generally considered that after the first week, the disease does not progress clinically, in the sense that new areas of the cord or medulla are involved, or that the affected areas become more severely damaged.⁹ Likewise, there is no evidence that there is continued damage to nerve cells after the first week. When a period of three months has elapsed after the acute attack of poliomyelitis, the only evidence of an inflammatory reaction is the presence of a few lymphocytes around the blood vessels. There is no good pathologic evidence to indicate that there might be a progression of the disease as late as three to six months after the acute stage. Therefore, it is not logical that the possibility of further progression of the disease, *per se*, should preclude active treatment of the disease for three to six months.

Treatment

The Acute Stage. Treatment of the acute stage of the disease will be discussed briefly. It is obvious that the most important treatment during this stage is that of saving life. This may entail emergency procedures. In this connection, careful observation of the patient for respiratory difficulty is important. Respiratory difficulty caused by involvement of the respiratory center in the medulla or of the centers which innervate the pharynx and larynx should be distinguished from the spinal type of respiratory difficulty. Pharyngeal paralysis is probably the most commonly encountered type of bulbar involvement. The aims of treatment of the condition are: (1) to maintain a free airway for effective respiration; (2) to minimize pulmonary aspiration of secretions. Meeting these two requirements will provide the patient not only with adequate oxygen, but also with rest. Death in cases of bulbar poliomyelitis with pharyngeal paralysis often is attributed to the extreme fatigue following a period of anoxia.

The first step toward realization of the aims

just described is to establish and maintain postural drainage. It is well to have the patient change his position at regular intervals, so that he will lie, at various times, on one side or the other, or on his abdomen with his head turned to one side. Electrical suction apparatus, fitted with a fairly soft catheter, to avoid trauma, is useful in assisting postural drainage. Children may become fearful and apprehensive regarding the use of the aspirator unless care is exercised in applying it. The pharyngoscope and bronchoscope are often effective in clearing the bronchial tree of mucus.

Nutrient and fluids should be given parenterally only, because solids or fluids taken by mouth might be aspirated. Administration of oxygen by tent or by positive pressure has helped to prevent anoxia, and at times, pulmonary edema.

However, the crucial problem in bulbar poliomyelitis is the prevention of anoxia, because brain tissue is highly susceptible to anoxia. Bulbar poliomyelitis, however, is not a single entity. It can be divided into four clinical groups, depending upon the region of the medulla involved and upon the pathologic process. The four groups are as follows: (1) the cranial nerve nuclei group; (2) the respiratory center group; (3) the circulatory center group, and (4) the encephalitic group, with more diffuse lesions.¹⁰

The most frequently recognized form of bulbar poliomyelitis is that in which the nuclei of the cranial nerves are involved. Destruction of the nucleus of the tenth cranial nerve greatly endangers the life of the patient, with pharyngeal paralysis consequently obstructing the airway and producing asphyxia. In poliomyelitis, however, selective lesions may occur within the autonomic centers of the medulla. This results in respiratory or circulatory failure, even in the absence of severe involvement of the cranial, intercostal and diaphragmatic nerves.

In the last four years there has been rather extensive use of tracheotomy in those cases of bulbar poliomyelitis in which there was pharyngeal paralysis. It has been fairly well established that the use of tracheotomy is a lifesaving procedure. The main indications for tracheotomy are as follows: (1) definite bulbar signs, usually a nasal voice and signs of interference with swallowing; evidence of

pooling of mucus in the throat and posterior pharynx, endangering the free airway, and (2) bulbar or spinal conditions in which the patient first appeared to be doing well, but in which anoxia gradually increases, either in or out of a respirator. Cyanosis may not be demonstrable; therefore, useful criteria of hypoxia are increasing pulse rate, headache and restlessness, despite what appears to be adequate respiratory exchange. Atelectasis and paralysis of vocal cords are also indications for tracheotomy. It should be stressed, however, that when tracheotomy is indicated, it should be done early. The advantages of tracheotomy are that mucus is easily removed from the respiratory tract and that adequate oxygen tension is more easily maintained. Pulmonary edema may be treated more easily by use of oxygen administered under positive pressure.

It is the general opinion now, that the mortality rate of bulbar poliomyelitis may be reduced considerably by the use of such procedures. When the tracheotomy is done, it is frequently necessary to use a respirator. However, in most instances, the use of the respirator in bulbar poliomyelitis may be contraindicated, unless a tracheotomy is done. The respiration of patients whose respiratory centers are primarily involved may be irregular, spasmodic and shallow. It is often difficult for such patients to assume the rhythm of the respirator. Therefore, the patient may struggle against the action of the respirator, and the resulting fatigue may be injurious. However, since the respiratory muscles of many patients with bulbar paralysis may be weak, it is often necessary for them to stay in the respirator for varying periods.

In the treatment of paresis of the respiratory muscles, the respirator is a lifesaving device. The patient should be carefully watched, and the respirator should be used before symptoms of serious lack of oxygen become obvious. This is true because anoxia, as has been stated, will injure nerve cells. Another reason has to do with fatigue. It is common knowledge that fatigue during the acute stage of poliomyelitis enhances the possibility of further paralysis. Therefore, the use of respirators, by preventing overexertion of the weakened respiratory muscles, which, if it occurred, would increase fatigue, may lessen the likelihood of further paralysis.

Treatment of the acute stage of the disease, in addition to care of the respiratory paralysis, includes general supportive measures, such as are used in any other infectious disease, proper splinting, and nursing care, some of which will be considered under the treatment of the convalescent stage.

The Convalescent Stage. — Treatment of convalescent poliomyelitis may be discussed in accordance with the factors involved in the disease; that is, pain, soreness, and tightness of the muscles, which are almost always present; and the weakness and paralysis which may be present.

As early as forty-eight hours after the patient has become afebrile, and within the first four weeks, an evaluation of muscular tightness and paresis should be carefully made and recorded and these evaluations should be repeated at regular intervals. These examinations should be made by the physician. Care should be taken to prevent increase of pain by the maneuvers of the examination, and to avoid fatigue. If need be, the examination can be done over a period of several days. The strength of the muscles should be recorded in accordance with the more or less standard grading system recommended by the National Foundation for Infantile Paralysis. This system is used by most neurologists in grading strength, and by those who treat poliomyelitis.

The extent to which soreness and tightness appear, obviously varies greatly in any group of convalescent patients following poliomyelitis. The tightness of muscles may last from a few days to several weeks and in rare instances, may last for several years. The muscles most commonly involved are those of the neck and back, the posterior muscles of the thigh and leg, the muscles around the shoulder, and occasionally the flexor groups of the thigh.

The paralysis likewise is extremely variable; the flexor muscles of the lower extremity, the quadriceps, the dorsiflexors of the foot, the shoulder abductors, and the flexors of the forearm are more often paralyzed or weakened by poliomyelitis than other groups. However, it is obvious that any group of muscles may be involved. Therefore, in the early stages of the disease, treatment must consist of several measures.

General Measures in Early Convalescence.

— When paralysis is present, measures should be taken to provide proper support of the extremities and to maintain correct bodily alignment. The use of boards under the mattress helps to maintain bodily alignment. Footboards aid in prevention of drop foot and help to prevent the bedclothes from pushing the feet down, thus decreasing the possibility of contractures. Rolled towels, sandbags, pillows, supports, and at times the use of light plaster splints may assist in keeping the extremities in the proper position. The position of the patient should be changed at frequent intervals during the twenty-four hours of the day. If the patient remains in one position, even though that position is anatomic, it tends to increase stiffness and may lead to contracture. It is the consensus that deformities of the bones result from the malposition produced by stretching weak or paralyzed muscles and by overactivity of opposing strong muscles. This is particularly true of the weight-bearing extremities and trunk.

The greatest difficulty relative to improper alignment is experienced in the treatment of young children. They are more active than older patients, and do not understand what is being done for them. They may lie in poor positions or stand on soft mattresses on weak or paralyzed extremities. Repetition of such acts may cause deformities. In the presence of these difficulties, good nursing care, close observation and restriction of movement, and the use of simple supports as mentioned previously, are essential. Rigid supports may be used, but should not be substituted for good care.

A general regimen of rest and supportive treatment should be used in almost any type of poliomyelitis, regardless of the extent of involvement, for at least the first three weeks.

Treatment of Muscular Tightness. — The treatment of the muscular tightness is important, because the function of muscle cannot be fully determined, and re-education and re-training done adequately, until the soreness and tightness are alleviated.

At the present time, various forms of heat are being used to relieve pain and soreness. The mechanism by which frequently applied hot packs relieve the pain of poliomyelitis and tend to produce muscular relaxation is not known. Neither is it known whether the

moist heat of the hot pack has any advantage over the other forms of heat. Possibly more easily applied forms of heat, used for the same frequency and duration as the hot packs are used, may be helpful. This, too, is not known.

Infra-red radiation has been considered effective.¹¹ Hot baths, at temperature of 104° F., administered after the communicable period of the disease, three or four times daily, for fifteen or twenty minutes, were considered by two observers to be more effective than the hot packs for relief of pain and stiffness.¹² To give the baths, a pool was used, where several patients could be treated at the same time.

The methods of applying hot packs have changed considerably. The meticulous procedure of applying hot packs to various segments of the body is not as widely used now as previously. In the past several years, use has been made of a so-called prone pack, although the patient can be either prone or supine. For this purpose, woolen cloths soaked in boiling water and wrung out, are merely dripped on the area, and insulating material is wrapped or tucked around them. In treating small children, the older type of pack, carefully wrapped to the part, is still necessary.

If the patient is in serious condition because of respiratory involvement, hot packs should be used with caution. However, after the febrile stage of the disease has passed, the patient can often be packed while still in the respirator, if it is done cautiously.

The period during which packs may be used varies. At one time the application of packs for six to twelve hours daily, changing them every fifteen minutes to two hours, was recommended. The present trend is to use the hot packs for a much shorter period, usually two to six hours daily. The frequency with which the packs are changed, and the time during which they are applied each day, depend somewhat upon the condition of the patient. If the pain, tenderness and muscular tightness are not severe, the rigor of the treatment may be reduced. Recent studies have indicated that the greatest increase in blood flow occurred when the packs were applied for fifteen to forty minutes.

Many have found that warm baths, used in conjunction with mild passive stretching

exercises, are as effective as hot packs, if not more so. At all events, in the majority of cases of poliomyelitis, if proper treatment is given, the pain and tenderness usually disappear in two weeks, and the muscular tightness in three to six weeks. It should be recognized, however, that heat alone will not eradicate muscular tightness.

Because muscular tightness and soreness definitely affect mobility, and if not relieved, tend to produce contractures, muscular imbalance and lack of co-ordination, these symptoms are of primary concern in the early treatment of poliomyelitis. Since heat alone does not affect muscular tightness essentially, the use of passive exercises becomes extremely important. There is some variance of opinion as to how vigorously passive exercises may be done; however, it is generally agreed that stretching may be fairly vigorous, if the muscular soreness and pain are not increased. These exercises should be carefully done following any form of thermotherapy. The procedure is that of attempting to take the part passively through a normal range of motion, gradually increasing the force of stretching until the muscle remains supple and of full length.

Patients with nonparalytic poliomyelitis or with minimal weakness may need treatment only to eradicate muscular tightness. Therefore, they may receive only such measures as heat and passive stretching exercises. It should be emphasized that the muscular tightness alone can produce imbalance and deformity in some instances. For that reason, nonparalytic patients should be followed until it is evident that no such deforming element has been overlooked. It is possible that some so-called idiopathic lateral curvatures of the spinal column are the result of imbalance due to muscular tightness following undiagnosed poliomyelitis.

Passive exercises are administered from the early stages of the disease, not only to obtain full mobility of muscle, but to stimulate the awareness of the weak muscles, and to attempt to reestablish normal patterns of motion and co-ordination.

Paralysis. — It is perhaps in the treatment of paralysis and weakness that the greatest strides have been made, as far as poliomyelitis is concerned. Patients can learn to do things well when they are muscularly well

co-ordinated, even though they may have little muscular power. It is evident that in poliomyelitis and other conditions in which peripheral nerve innervation is partially or completely disrupted, in-co-ordination results from disordered reciprocal innervation. It has been found by electromyographic recordings that muscles with antagonistic functions are simultaneously activated. The severity of this abnormality is decreased by reeducation of muscles and relief of pain.

In addition to actual disturbances of reciprocal innervation, other factors are involved in disruption of patterns of motion. The action performed by muscle groups is represented in the brain as a motion, and not as the specific muscle which produces it. Therefore, when the nerves which supply a muscle or group of muscles are wholly or partially disrupted, the brain still attempts to initiate motion by sending impulses to the region along the intact nerves. If motion similar to that produced by the weakened or paralyzed muscle is accomplished readily by a neighboring group of muscles, even though the muscles which produce the motion are remote from or opposed to the weak or paralyzed muscles, the patient continues to practice that motion. If he is unsupervised, undesirable patterns of motion result, which may be difficult to overcome. This substitution results in in-co-ordination. Such actions are commonly exemplified by contraction of the hamstrings in a vain attempt to produce extension of the knee in cases of paralysis of the quadriceps. It is common to see the action of a weak anterior tibial muscle disappear entirely in the presence of overaction of the toe extensors.

Such results are also partially the basis for the belief that fatigue is responsible for the disappearance of the function of weak muscles. Actually, fatigue probably plays a part only in the sense that a weak muscle tires quickly and temporarily ceases to function. Also, a weak muscle may be stretched beyond its optimal length for functioning. If the patient continues to be active, the stronger muscles are used to produce motion, although inadequately. The weak muscles become suppressed, and finally cease to act, and a new pattern of motion is developed. It is believed that if the functioning muscles in a case of poliomyelitis can be kept at normal length,

and if in-co-ordination and substitutionary movements are not established, deformities can be prevented. Bennett¹³ expressed the belief that it is lack of co-ordinated movement, rather than paralysis, which causes deformities. However, it is not only difficult, but if any delay in treatment has taken place, it may be physiologically impossible, to prevent strong synergistic muscles from taking over the function of the weaker ones. It can be readily seen, therefore, that careful, highly skilled re-education of weakened muscles cannot be overemphasized. It can also be readily recognized that it is extremely important for the patient to become well co-ordinated before he begins to do exercise which may be beyond the strength of the muscles.

The patient should be carefully instructed in what is expected of him. Exercise should not be so strenuous as to cause pain, for it is obvious that muscles are not able to do co-ordinated action when such motion produces pain. The physician should be well aware of how much can be expected of muscles with a given strength. It is also important that all movements of the muscle should follow normal patterns of motion as closely as possible. All active exercise should be carefully graded, in order that the muscles do not attempt to produce motion against a force too great to accomplish that motion, and thereby require substitution of other groups. It should be remembered that fatigue is not dangerous, unless carried to the extent that the muscle ceases to function, thereby producing in-co-ordination and substitution for the muscles. If the patient is of sufficient age to understand, he should be carefully instructed as to activities between his treatment periods.

The training of patients in co-ordinated movements is done by carefully tugging on the tendons of each muscle or group of muscles to stimulate the proprioceptive sense and to attempt to establish awareness of what motion is produced. At first an attempt to obtain isolated motion of the individual weak or paralyzed muscles or groups of muscles is made. Later, as power returns, co-ordinated active motion involving normal patterns of motion is attempted. These patterns of motion are established by carrying the part through motions normally used in various activities. Training must be frequent.

The patient's general activities should be

carefully guided and guarded, in order that undesirable patterns of motion may not develop.

Training of the patient in co-ordinated movement in such a manner that all groups of muscles function to the best advantage, so that weak muscles are used and developed properly, requires special skill on the part of the therapist and careful observation and judgment on the part of the attending physician. Weeks or months may be required to decide whether maximal benefits have been reached.

An attempt to increase the strength of muscle always has constituted an important phase in the after-treatment of poliomyelitis. As voluntary control returns, active exercise of individual muscles or groups of muscles is instituted. The amount of exercise is increased as muscle power increases; that is, from movement with assistance to movement with force of gravity eliminated; and then to movement against both force of gravity and resistance. Careful attention must be given at all times to see that motion is co-ordinated, and that no substitutionary movements are exhibited. As muscle power increases, in-co-ordinated movements may be developed. Muscles do not recover strength at the same rate, and it can readily be seen that the so-called in-co-ordinated movements can appear at any stage in recovery of the various groups of muscles.

The general activities of the patient are increased as muscle strength returns and co-ordinated movement is established. Some workers do not allow the severely involved patients to sit, or stand, or become increasingly active, for long periods. It is believed, however, that as soon as soreness and pain have disappeared, the patient may increase his activities to his maximal ability, as long as the movement is well co-ordinated. The trend is away from the long period and curtailment and toward earlier activity.

The activities of the patient often are curtailed in the belief that fatigue will produce further weakness, or that activity may increase the possibility of exacerbation of the disease. However, the danger of development of undesirable patterns of motion through lack of co-ordination that is produced by strenuous exercise is probably of greater importance than fatigue. As has been stated

before, there is no pathologic evidence to indicate that there is any activity of the virus after the first two weeks of the disease. Keys¹⁴ stated that exercise which causes no fatigue is of little benefit, and that there is no reason to support the view that active exercise is harmful in most diseases. Palladin¹⁵ found that rhythmic constructions led to increased work capacity of muscles.

As activity is increased, further use should be made of supports of various kinds to hold weakened and paralyzed parts in positions which will not encourage substitutionary movements, and which will enhance development of co-ordinated action.

These may include slings to support the weight of the arm in weakness of the deltoid muscle, in order that subluxation of the shoulder may not occur; corsets or jackets to prevent curvature of the spinal column; various splints for the hand, in paralysis or weakness of the flexors or extensors of the fingers; splints for the thumb, in case of paralysis of the opponens pollicis muscles; various types of braces for the lower extremities, to prevent excessive shortening or lengthening of muscles or tendency toward in-co-ordinated motions.

There is the belief that appliances such as braces, corsets and splints are not necessary and that they hinder ultimate recovery. It appears unreasonable, however, to curtail activity of the patient for long periods when appliances may allow him to become active without danger of causing deformity or muscular imbalance. Likewise, it should not be assumed that if a patient can carry on certain activities, for example, walking without braces when both legs are paralyzed, deformities may not develop in later years. Furthermore, in such instances, instability may curtail his activities to such an extent as to overshadow the inconvenience of wearing the supports.

In addition to trying to increase muscular strength and bring about the best possible function of the remaining muscles, the patient must be physically rehabilitated to the greatest possible degree. This is especially true when the patient has had extensive involvement as a result of the disease. Therefore, in addition to the program of re-education and the attempt to develop co-ordination, a general program leading toward com-

plete rehabilitation must be initiated. As soon as the patient has been relieved of the pain and tightness of the muscles, he may begin certain types of bed exercises. He should be encouraged to do some of his own toilet. He should have a trapeze on the bed, with which he may do stretching exercises and co-ordinated strengthening exercises under the supervision of a therapist or physician. Various types of apparatus, such as clings, may be placed on the bed for active assistive or resistive exercises, and to assist him to do co-ordinated activities in his daily living. When the patient gains strength to the point where he may be in a sitting position, he may be taught certain activities in a wheel chair, such as how to propel it, how to get in and out of the chair, how to dress himself; he may be encouraged to do all kinds of activities which may be diversional, or for the purpose of developing his muscular power and co-ordination.

Occupational therapy may be used at this time to develop endurance and co-ordination of the various groups of muscles of the arm and hand.

As muscle power returns to the point at which the muscle can move the part with gravity eliminated, or where it is barely able to lift against gravity, specific progressive resistive exercises may be used. These exercises can be done by using slings counterbalancing the part, so that normal motion can be done with part of the weight eliminated. This allows movement with gravity eliminated. Resistance can be added by having the part push or pull sandbags. The resistance should be carefully graded and increased. The exercises must be carefully supervised. If not supervised, resistive exercise may do more harm than good.

The patient may be put on the athletic mat and given definite exercises to develop all muscles which function against gravity, in order that he may develop endurance and training necessary to walk. These general activities for development of strength and endurance may consist of pulling graduated weights on pulleys, or the use of dumbbells or weighted boots. The patient also may do push-ups, rolling, crawling, scooting along in a sitting position forward and backward, and may use short crutches in a sitting position to develop practice in the crutch gaits.

When the patient has reached the stage in which he has sufficient power of the upper extremities (in case of paralysis of the lower extremities), he may be placed in high parallel bars and taught further co-ordination and gait training. When he has developed a well co-ordinated gait while using the parallel bars, he may be started on crutch walking. Any one of the various crutch gaits which are applicable to the individual must be taught. During this period he is taught to get in and out of ordinary chairs, his wheel chair, and chairs of various heights. He is taught to climb stairs and to go over curbs. Most of the walking and other activities should be done under direct and careful supervision until the patient is so trained that he continues to do them correctly by himself.

Patients who have weakness and paralysis of both upper and lower extremities may often be trained to use special types of crutches, and with braces, may learn to walk sufficiently well to be practical.

Time does not allow discussion of all the possible paralyses of poliomyelitis. In general, the treatment of the less severely involved patients consists of strengthening of muscles, training in co-ordination, use of the best possible gaits in involvement of the lower extremities, teaching of substitutionary movements when possibilities of recovery no longer exist, and proper bracing to prevent deformities.

The general period of time for which patients with residual poliomyelitis should be treated is often difficult to decide. In general, when weakness and paralysis are present, the patient should continue treatment until there is no further increase in power of the muscles, and until there is good co-ordination. If there is total paralysis of a whole segment, the prognosis for recovery of power is poor. Therefore, the program of treatment of these patients after three to six months have elapsed should be one including support of the part and rehabilitative measures which will train the patient to become active with what he has left.

In most instances, it is not necessary to wait months before the various stages of rehabilitation are started. They should be started as needed, from the time the patient becomes active. Not infrequently in the past patients have been given extensive treat-

ments in the form of hot packs, re-education and training, and then have been allowed to return home, having had little or no training relative to handling themselves independently. Frequently little or no guidance has been given the patient relative to his future life. This has been left to the family, or to the social agency. These patients must be treated as a whole, as any severely handicapped patient is treated, and treatment can be considered as partial failure if this is not done. The patient's family, in most instances, cannot adequately finish rehabilitation of the patient.

The final stage of treatment of poliomyelitis consists of permanent use of orthopedic appliances and correction of deformities and the production of stabilization by surgical means. The stage of recovery at which these measures may be indicated is probably reached earlier at present than formerly.

The treatment of poliomyelitis is still inadequate; however, disabilities and deformities caused by the disease are not as much feared as they were at one time. Treatment of the convalescent and chronic stage of poliomyelitis should be supervised from the beginning by a team of workers skilled in the treatment of skeletal muscular disease in general, and poliomyelitis in particular. Responsibility for the care of the patient should be entirely in the hands of a physician. The physician should make every effort to gain the knowledge necessary to supervise and care for these patients properly. The ideal team for the treatment of convalescent poliomyelitis ordinarily would consist of the physiatrist, the orthopedic surgeon and the physical therapist. Since there is a trend toward all-inclusive treatment, it may be necessary to add to the team the occupational therapist, the psychologist and the social worker.

It should be further emphasized that all poliomyelitis patients should be examined carefully one to three times a year for several years.

The treatment of poliomyelitis presents an extremely variable problem, physical, social and economic. Treatment must be highly individualized and adapted to the patient's needs. The poliomyelitis patient is justified in feeling that his physician should be one

(Continued on Page 73)

Minutes of Council Meeting

Marvin Hughitt Hotel, Huron, S. D.

January 14, 1951

In the absence of the Chairman, the meeting of the Council was called to order by Dr. D. A. Gregory, Milbank, President-Elect and former Chairman of the Council, at 1:15 P. M. On roll call the following were present: President, L. J. Pankow, Sioux Falls; President-Elect D. A. Gregory, Milbank; Vice-President R. E. Jernstrom, Rapid City; Secretary-Treasurer R. G. Mayer, Aberdeen; Executive Secretary John C. Foster, Sioux Falls; Speaker of the House H. Russell Brown, Watertown; Councilors J. D. Alway, Aberdeen District; Rodney Stolz, Watertown District; M. M. Morrissey, Pierre District; B. T. Lenz, Huron District; F. D. Gillis, Mitchell District; R. E. Van Demark, Sioux Falls District; A. P. Reding, Yankton District; A. A. Lampert, Black Hills District, R. J. Quinn, Rosebud District; A. W. Spiry, Northwest District, F. F. Pfister, Whetstone Valley District; and W. H. Saxton, Huron, Councilor at Large. Seventeen officers of various District Medical Societies were also present.

Since the minutes of the September meeting were published in the October issue of the South Dakota Journal of Medicine and Pharmacy a motion was made by Pfister, seconded by Spiry, and carried that the reading of the minutes of the previous session be dispensed with.

The report of the Sub-committee on Legislation as presented by the Chairman, Dr. M. M. Morrissey, was taken up in detail, with Executive Secretary Foster summarizing the contents of the various bills. The group of bills sponsored by the State Health Department were taken up first. A motion was made by Pankow, seconded by Jernstrom, and carried that the Council approve the so-called "Grade A Milk" bill. A motion was made by Spiry, seconded by Pfister, and carried that the bill which would be an enabling act authorizing the formation of Health Districts by two or more counties be approved. A motion was made by Quinn, seconded by Jernstrom, and carried that the bill which would license homes for the aged under

the State Department of Welfare be approved. A motion was made by Jernstrom, seconded by Stoltz, and carried that the bill which would amend the act providing for Premarital Blood Tests be approved. A motion was made by Alway, seconded by Reding, and carried which would amend the act providing for the recording of Vital Statistics be approved. The Sub-committee on Legislation did not endorse the bill providing for licensure of plumbers, and a motion was made by Jernstrom, seconded by Stoltz, and carried that the report of the Sub-committee be accepted.

A motion was made by Gillis, seconded by Saxton and carried that House Bill No. 145 providing for autopsies in certain cases be endorsed. A motion was made by Reding, seconded by Alway, and carried, endorsing a bill regulating the practice of optometry which was being introduced by the optometrists. A motion was made by Stoltz, seconded by Gillis, and carried; endorsing a bill which would provide material for medical research. A motion was made by Pankow, seconded by Reding, and carried, endorsing a bill which would require annual registration of all doctors of medicine and osteopathic physicians with a registration fee of \$2.00. A motion was made by Brown, seconded by Stoltz, and carried, that a resolution be introduced at the discretion of the Sub-committee on Legislation and the attorney of the S. D. State Medical Association, the resolution memorializing Congress against Compulsory Health Insurance Legislation. A motion was made by Van Demark, seconded by Pankow, and carried, that a resolution be sent to Dr. G. J. Van Heuvelen, State Health Officer, advocating that salaries of employees of the State Health Department be raised so that they would compare favorably with salaries paid to employees of similar positions in neighboring states. A motion was made by Alway, seconded by Pankow, and carried, that the Council endorse an amendment to the Basic Science Law as proposed by the

Basic Science Board at the discretion of the Sub-committee on Legislation and Attorney Goldsmith.

A motion was made by Stoltz, seconded by Quinn, and carried, endorsing an amendment to the Workmens Compensation Law which would remove the present limits on payments for medical and hospital care. A motion was made by Stoltz, seconded by Reding, and carried, approving the recommendation of the Committee on Medical School Affairs to increase the biennial appropriation to the medical school for the new building and equipment needed to conduct a Class A. Medical School. A motion was made by Gillis, seconded by Lenz, and carried, that the Council endorses the recommendation of the Committee on Medical School Affairs to President I. D. Weeks of the University of South Dakota that a plaque in honor of Dr. J. C. Ohlmacher, former Dean of the University of South Dakota Medical school, be placed in the new medical school building.

The tentative program for the Annual meeting to be held in Aberdeen June 2 — 6 was outlined by Secretary Mayer and general discussion with numerous suggestions followed. President Pankow announced that the South Dakota Academy of General Practitioners have suggested that Dr. T. F. Riggs be proposed as General Practitioner of the Year for South Dakota. President Pankow announced that he had received information regarding the formation of the Medical Students A.M.A., requesting the appointment of a Councilor from the Yankton District Medical Society for the student organization and Dr. A. P. Reding, Councilor of the Yankton District, was requested to carry the information to his District Society. A motion was made by Pankow, seconded by Jernstrom, and carried, that the Council name a Councilor to represent the State Medical Association with the Student organization. A motion was made by Pfister, seconded by Brown, and carried, that the President of the South Dakota State Medical Association act as Councilor to the Medical Students A.M.A. organization at the University of South Dakota Medical School.

President Pankow announced that he had received the resignation of Dr. C. E. Sherwood, Madison, as Chairman of the Committee on Prepayment and Insurance Plans,

and that he had appointed Dr. C. J. McDonald, Sioux Falls, in his place. General discussion of prepayment insurance plans followed. Executive Secretary Foster announced that the term of Dr. J. D. Alway on the Basic Science Board would expire July 1st. A motion was made by Gillis, seconded by Pankow, and carried, that Dr. J. D. Alway be nominated for reappointment to the Board. A motion was made by Brown, seconded by Pankow, and carried, that Executive Secretary Foster make suitable inquiries of the officers of the various component district medical societies regarding realignment of the various districts in the State. On motion the meeting adjourned at 3:00 P. M.

R. G. Mayer, Secretary

REPORT OF DELEGATE TO AMA ANNUAL MEETING

June 26-30, 1950

The 99th annual meeting of the American Medical Association was held at San Francisco, June 26-30, 1950. More than 10,000 fellows and members attended and the total registration reached almost 24,000.

Dr. Evarts A. Graham of St. Louis, Missouri was granted the Distinguished Service Award for 1950. His accomplishments in the fields of lung surgery and gall-bladder radiography particularly need no elaboration in this report.

John W. Cline of San Francisco is the new president-elect of the AMA. R. B. Robins, Camden, Arkansas, was elected Vice-President. Officers re-elected were: J. J. Moore, Chicago, Treasurer; F. F. Borzell, Philadelphia, Speaker of the House; James R. Reuling, Bayside, New York, Vice-Speaker; Geo. F. Lull, Chicago, Secretary. Elected to the Board of Trustees were: Leonard W. Larson of Bismarck, North Dakota, and Thomas P. Murdock of Meriden, Connecticut.

Your delegate attended two other meetings which were held on the Sunday preceding the opening of the AMA Meetings. These were the "Seventh National Conference of County Medical Society Officers," and the "Conference of Presidents and officers of State Medical Associations." Both conferences were concerned with medical economics and attendance was well worth the time.

The House of Delegates had its usual busy session and acted on more than 170 pieces of

business. The Hess Report was adopted with minor and inconsequential amendments. It was resolved to oppose the President's Reorganization Plan, #27. Because federal subsidy always means eventual federal control, it was felt necessary to oppose federal aid to medical education. Dues for 1951 were fixed at \$25 and include the subscription to the Journal of the American Medical Association. Fellowship dues are \$2.00 additional and privilege the fellow to select another AMA scientific publication in lieu of the Journal of the AMA.

The Board of Trustees was authorized and directed to initiate and encourage development of a Junior AMA organization for medical students. Other items in the agenda were too numerous to be discussed in this report, but detailed information in their regard appears in the Journal.

The report of the Coordinating Committee for the National Education Campaign was approved. The Board of Trustees expressed satisfaction in the work of Whitaker and Baxter and retained them for another year.

The Session of the House of Delegates was notable in that, for the first time, the final session was broadcast over a dual-network, coast-to-coast radio hook-up. The broadcast included the addresses of retiring President, Ernest E. Irons; President, Elmer L. Henderson; and President-Elect, John W. Cline.

Respectfully submitted,
H. Russell Brown, M.D.
Delegate to AMA

REPORT OF DELEGATE TO AMERICAN MEDICAL ASSOCIATION CLINICAL SESSION

December 5-8, 1950, Cleveland, Ohio

Despite the severe blizzard that blanketed the Great Lakes and Cleveland area during the week preceding the meeting, physician attendance at this clinical session was very satisfactory. Approximately 2,100 physicians attended the program and scientific exhibits, which were of the same high quality characteristic of past clinical sessions.

After travel difficulties due to poor flying weather, and using both plane and train, I arrived at Cleveland, Sunday morning, December 3, to attend special committee meetings. On December 3rd and 4th, several sessions of the Public Relations Conference were

attended. This was the third annual conference of this type and the program was excellent and well attended.

The Sessions of the House of Delegates opened on Tuesday morning and 195 of the 198 delegates were present. The fourth recipient of the Association's "Gold Medal" for exceptional services by a general practitioner" is a 74-year-old family doctor practicing at Canton, Massachusetts, Dr. Dean Sherwood Luce. Other nominees for this recognition were: Dr. Jim Camp of Pecos, Texas, Dr. John Strange of Loogootee, Indiana. A large amount of business was handled by the House more smoothly and rapidly than in any previous session. This report will not recount the many items of business taken up, but will refer you to the reports in the Journal of the AMA for detailed information.

Three outstanding things occurred at this meeting and these should be commented upon in this report for emphasis. The most noteworthy of these was the action taken by the Board of Trustees with the endorsement of the House of Delegates, in allocating one-half million dollars of AMA funds to the medical schools without any strings attached. It is hoped that it will be the beginning of a fund of money raised by private donation and philanthropy to assist in the financing of medical education; thereby making unnecessary federal subsidy with its inevitable resulting federal control.

Of importance also was the very favorable report of the coordinating Committee for the National Education Campaign. Great strides have been made in telling medicine's story to the people. As a result the American people in ever increasing numbers are rallying to the support of the medical profession in its fight against socialization of medicine and the drift toward state socialism of our economy in general. During the past year, the number of people covered by voluntary health insurance has increased more rapidly than ever before. While much more work remains to be done and conditions will not permit resting on the oars, it is reassuring to know that tangible and rapid progress is being made in our crusade.

The third occurrence of outstanding importance was the presentation of an address

(Continued on Page 73)



PRESIDENT'S PAGE

L. J. Pankow, M.D.

March Message

There are many very good reasons for again referring to the South Dakota Medical School Endowment Fund at this particular time. Two recent events should dramatically direct our attention to this matter right now. One is Income Tax Day, and the other is an action of the American Medical Association.

Recently the American Medical Association gave half a million dollars for use by Medical Schools that are in need of financial help. This money is without any attached provisos other than that the school needs it. Federal Administrative Forces are trying to pass a measure to force money onto Medical Schools, despite the fact that leading minds of our profession have declared against the idea. Any time the Federal Government gives (?) anything away there are plenty of strings attached to the gift. Medicine belongs to no political party, but a request for money from any Political Bureau would bet dubious results unless some inference of support of Party Ideals was given along with the request. Submission to the terms of a grant would in fact be acceptance of the ideals of that Bureau. Consequently Party Affiliation of the instructors and heads of these Medical Schools could very well have more effect on financial help than the academic or scientific ability of the faculty. What price ABILITY if party affiliation is at a premium? Any protestations to the contrary emanating from Washington should be listened to with memories of previous vote seducing promised. Lower Taxes and a balanced budget were empty promises of the last National election.

Higher taxes are here NOW, and you are facing the certainty of a still bigger slice from your earnings. The money is going to be taken out of your net earnings, regardless, but there is a way you can dictate where some of it will go, yourself. Gifts to Charitable and Tax-exempt Corporations are deductible from your net income tax. Such a Corporation is our Medical School Endowment Fund Cooperation, and gifts made to that fund are deductible from your Income, and so lowers the amount on which you must pay tax by the amount of your donation. At the same time you have had the satisfaction of spending that Tax Money directly, and where it is doing YOU some good, instead of having it wasted by the questionable ministrations of Federal Bureaus.

SUMMARY:

1. The American Medical Association advocates private support of our Medical Schools, and has started the movement to the tune of half a million dollars.
2. You can spend some of your own tax money by donating to the South Dakota Medical School Endowment Fund Corporation, because your donation is deductible from your Net Income.
3. By freely endowing our Medical School we can relieve any urge for a request for free (?) money from Washington, which is actually bait to secure submission to Federal Bureaucratic dictation.

CONCLUSIONS:

1. Write a LIBERAL check to the South Dakota Medical School Endowment Fund Corporation.
2. Dont be satisfied because you have contributed before. It is a deductible item each year.
3. Mail the checks to Donald Slaughter, M.D., Dean of the Medical School in Vermillion, or to John C. Foster at the South Dakota State Medical Ass'n office, 300 First National Bank Bldg., in Sioux Falls.

SPEND YOUR OWN TAXES ON YOUR OWN PROJECT. GIVE TO MED. EDUCATION

EDITORIAL PAGE

DANGERS OF FEDERAL SUBSIDY

Warning against the dangers of Federal subsidy as a means of providing financial aid to medical schools, Dr. Elmer L. Henderson of Louisville, President of the American Medical Association, urged nationwide support of a newly-established fund for aid to medical education.

Dr. Henderson spoke at the Hotel Biltmore before a dinner meeting marking the enrollment of the two-millionth member of the United Medical Service, the Blue Shield surgical and medical insurance plan operating in the Metropolitan New York area.

"Assuring an adequate future supply of doctors, through American methods which will preserve the standards and freedom of medical education, is of vital importance to the continued success of the medical care plans, to all those engaged in the provision of health services and to every American citizen," Dr. Henderson said.

"The medical profession is willing to take the lead, but it also needs and asks the help of all Americans who prefer initiative and enterprise to Government domination and control."

Dr. Henderson reported that the American Medical Education Foundation has been organized under the laws of Illinois as a non-profit corporation for the receipt of funds for medical education. Establishment of the Foundation followed earlier action by the Board of Trustees of the American Medical Association, which last December appropriated half a million dollars as the nucleus of a fund to be raised for the aid of medical schools throughout the Nation.

Paying high tribute to the United Medical Service for "vigorous, progressive development during its six and one-half years of existence," Dr. Henderson said that its achievement "is representative of the rapid growth and development, and the promising potentialities, of all the Voluntary Health Insurance plans throughout the entire Nation."

Dr. Henderson said all agencies in the health insurance field are reporting rapid

growth, improved coverage and new developments. He estimated, on a basis of preliminary reports on 1950 progress, that between seventy and seventy-two million Americans now have some form of Voluntary Health Insurance.

The advocates of socialized medicine, he added, "are fast losing all semblance of a case."

GULLIBLE'S TRAVELS

January 10 — The legislature is still moving slowly but things should pick up soon. Attended a legislative dinner at the Legion Hall in the evening.

January 12 — Attended a meeting of the Governor's Committee on Children and Youth in the Governor's reception room to determine plans for the future as far as the committee is concerned. Drove to Sioux Falls that evening.

January 13 — Drove to Huron in the morning with my son, Eddie, to attend several meetings. Met with the Medical School Endowment Fund Directors and watched as they accepted a gift of property from **Dr. E. M. Stansbury** of Vermillion.

That evening the S. D. members of the General Practice Academy met for dinner and to transact their business.

January 14 — In the morning, I attended the Annual Meeting of District officers and councilors and in the afternoon met with the Council.

The rest of the time up to January 27 was taken up with legislative activities with the exception of weekend dashes for Sioux Falls to try to catch up on routine office work. The recess, starting January 28, saw Gullible back in Sioux Falls and on occasion appearing on station KELO and before the Chamber of Commerce.

February 3 — In addition to the legislative rat race — attended a luncheon of the directors of the State Mental Health Ass'n. From here on in, its all legislation — except that on Friday, February 23, I met with Messrs. **Covey** and **Larsen** of the Winner Hospital to discuss some of their problems.

(Continued from Page 67)

who has studied the anatomic function of normal muscles, who has seen many forms of paralytic disease, and who can apply wisely his knowledge and experience.

REFERENCES

1. Bodian, David and Howe, H. A.: Neurotropism and the Genesis of Cerebral Lesions in Poliomyelitis: An Experimental Study. *Bull. Johns Hopkins Hosp.* 68:58-74, 1941.
2. Bodian, David and Howe, H. A.: An Experimental Study of the Role of Neurones in the Dissemination of Poliomyelitis Virus in the Nervous System. *Brain.* 63:135-162 (June) 1940.
3. Warburg, Bettina: Experimental Poliomyelitis; Histology of the Persistent Lesions of the Central Nervous System. *Arch. Neurol. & Psychiat.* 25:1191-1232 (June) 1931.
4. Bodian, David: Poliomyelitis: Pathologic Anatomy. In: Poliomyelitis; Papers and Discussions Presented at the First International Poliomyelitis Conference. Philadelphia, J. B. Lippincott Company, 1949, pp. 62-84.
5. Sabin, A. B. and Ward, Robert: Nature of Non-paralytic and Transitory Paralytic Poliomyelitis in Rhesus Monkeys Inoculated With Human Virus. *J. Exper. Med.* 73:757-770 (June 1) 1941.
6. Minckler, Jeff: Pathologic Alterations in Surface Relationships and Morphology at the Human Synapse. *Am. J. Path.* 18:1061-1100 (Nov.) 1942.
7. Bouman, H. D. and Schwartz, R. P.: The Degree, the Extent, and the Mechanism of Muscle Spasm in Infantile Paralysis. *New York State J. Med.* 44:147-151 (Jan. 15) 1944.
8. Kabat, Kerman and Knapp, M. E.: The Mechanism of Muscle Spasm in Poliomyelitis. *J. Pediat.* 24:123-137 (Feb.) 1944.
9. Bell, E. T.: The Progressive Pathology of Poliomyelitis. In: Poliomyelitis; Papers and Discussions Presented at the First International Poliomyelitis Conference.
10. Baker, A. B.: Neurologic Signs of Bulbar Poliomyelitis. In: Poliomyelitis; Papers and Discussions Presented at the First International Poliomyelitis Conference. Philadelphia, J. B. Lippincott Company, 1949, pp. 241-244.
11. Toomey, J. A.: Treatment of Infantile Paralysis in the Acute Stage. *Arch. Phys. Therapy.* 23:650-662 (Nov.) 1942.
12. Gurewitsch, A. D. and O'Neill, Margaret A.: Hot Baths in the Treatment of Early Infantile Paralysis. *J. Pediat.* 28:554-565 (May) 1946.
13. Bennett, R. D.: Physical Medicine in Acute and Convalescent Poliomyelitis. *Clinics.* 4:1516-1528 (Apr.) 1946.
14. Keys, Ancel: The Physiology of Exercise in Relation to Physical Medicine. *Arch. Phys. Med.* 26:633-638 (Oct.) 1945.
15. Palladin, A. V.: Biochemistry of Muscle Training. *Science.* 102:576-578 (Dec. 7) 1945.

(Continued from Page 70)

to the House of Delegates and a nation-wide radio audience by an outstanding leader in union labor. William H. Hutcheson is general president of the United Brotherhood of Carpenters and Joiners of America, and Vice-president of the A. F. of L. His address was entitled, "Socialized Medicine is No Bargain." He stated that his union representing 800,000 members had voted opposition to compulsory

health insurance. He pledged support to the medical profession in its fight against socialized medicine and state socialism. His address has appeared in the *Journal of the AMA* and should be read by every doctor.

Permit me to express my appreciation for the privilege and honor of representing the South Dakota State Medical Association as its delegate.

Respectfully submitted,
H. Russell Brown, M.D.
Delegate to AMA

CUFF NOTES

UNDIAGNOSED RECTAL SYMPTOMS

Unexplained high rectal pains, persistent coccygeal pains, pressure discomforts of rectal constipation, cancerphobia of the rectum, rectal urge or tenesmus, of diarrhea, should first be studied organically (sigmoidoscope, colon x-ray) then considered for psychosomatic tendencies.

HEAD INJURY IN THE CHILD

The child whose head is injured, or bumped should be carefully watched for: 1. A period of apparently normal behavior, 2. later development of stupor or coma or convulsions, fever, dilatation of one pupil, any of which indicate that an extradural brain hemorrhage is developing. Immediate neuro-surgery is needed, with removal of the clot, if a 50% death rate is to be avoided. Barnes Woodhall, M.D. *Southern M. J. Apr.* 1949.

REMOVAL OF SPLINTER UNDER NAIL

When a Splinter has been driven under a finger or toe nail, and broken off so that it cannot be reached with forceps, a very useful procedure, especially in children, is to soften the nail by 1. soaking the nail in warm water, 2. pare down the nail with a sharp scalpel or razor blade and thus removing a piece of nail over the splinter and giving direct access to it. After removal protect the gap in the nail by applying collodion, or adhesive tape. J. G. Bonin, *Medical World.*

HEART COMPLICATIONS DUE TO GALL-BLADDER DISEASE

Anginal pains and cardiac irregularities are often due to gallstones and chronic cholecystitis. Removal of the gall-bladder relieves such patients and improves cardiac function. W. Walters, *Texas S. J. M. Jan.* 1949.

(Continued on Page 76)

This is



MARCH
1951
Vol. 4 No. 3

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Student medical Group Forms at USD

The Student American Medical Association has completed organization of a chapter at the University of South Dakota Medical School.

Lloyd L. Olson, Langford, was named president. Other officers are **Wyllis G. Larson**, Sisseton, vice-president, and **Nancy Anne Lee**, Parker, secretary-treasurer.

The advisory committee is made up of **Dr. Harry Clausen**, **T. E. Eyres**, and **Donald Slaughter** representing the Medical School, with **Drs. A. P. Reding** and **L. J. Pan-kow** representing the Medical Association.

NEWS NOTES

F. E. Boyd, M.D., of Flandreau has sold his practice to **Marvin Hurewitz, M.D.**, formerly of Colman. Dr. Boyd has not announced his future plans.

The Madison Junior Chamber of Commerce named **Dr. D. S. Baughman** as the city's outstanding older citizen.

Bryant has recently opened a new clinic which will be occupied by a **Dr. Fershing**, newly arrived in the State.

ABERDEEN DISTRICT HEARS MATSON

The Aberdeen District Medical Society held a dinner and business meeting Wednesday, January 24th at the Sherman Hotel Banquet room.

Dr. G. A. Matson, Director of the Minnesota War Memorial Blood Bank, Minneapolis, gave a talk on "Blood Procurement in National Defense."

A forty minute movie on "Subtotal Gastrectomy" by **Dr. Philip Thorek** of Chicago, was shown.

The new Constitution and By-Laws were adopted and three Directors were elected to the Executive Committee: **Dr. R. G. Mayer** for one year; **Dr. B. C. Murdy** for two years and **Dr. Paul V. McCarthy** for three years.

The Fourth Annual Post-graduate Course in Diseases of the Chest sponsored by the American College of Chest Physicians, Pennsylvania Chapter and the Laennec Society of Philadelphia, will be presented at the Hotel Warwick, Philadelphia, Pennsylvania, March 26-30, 1951.

This course will emphasize the recent developments in

all aspects of the diagnosis and treatment of chest disease. The course is open to all physicians; however, the number of registrants will be limited. The tuition fee is \$50.00 and applications will be accepted in the order in which they are received. Applications should be sent to the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

Through a typographical error a middle initial appeared wrongly as co-author with Slaughter and Hawkins in the article, "The Actions of Organically Bound Iodine," South Dakota Journal Medicine and Pharmacy, 3:357, Dec. 1950. The name should have appeared as **W. W. Grover** rather than **W. C.**

"The Committee on Prepayment and Insurance of the S. Dak. State Medical Ass. has endorsed the hospital and surgical policy of the Paul Revere Co. This policy is non-cancellable once the premium is paid. The Committee also has other policies under consideration for endorsement."

C. J. McDonald, M.D.
Chairman

PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor

REPORTERS WANTED

Be YOUR OWN REPORTER. Lets have more news for your fellow pharmacists. Simply address a card or letter to C. F. Van De Walle, Sioux Falls, S. D. or to the Journal and let us know of any additions to the family, changes in personnel, remodeling of the store or any other items that might be of interest to your friends. We also will welcome any article of interest to pharmacists and any suggestion for improving this section of the Journal. This is YOUR Journal, so if you have anything to "get off your chest" let us know.

The Commercial and Legislative Section of the S. D. Ph. A is to be the drug store owner's organization within the South Dakota Pharmaceutical Association. The organization meeting of this section will be one of the features of the Watertown convention. Addresses and topics relating to the commercial side of the drug business will be included in the Section Program under the Chairman, A. O. Bittner, who is now First Vice-President of the association. The Secretary reported to the Executive Committee that a majority of South Dakota drug stores had already applied for membership and that there were forty or more stores participating in the VA RX program which have not yet applied. Non-member stores are urged to send in their applications at an early date. The Executive Committee voted to include a subscription to the South Dakota Journal of Medicine and Pharmacy for all MEMBER drug stores for the 1951 calendar year.

BOARD OF PHARMACY EXAMINATIONS TO BE CONDUCTED AT BROOKINGS JUNE 5, 6, 7, 1951

The State Board of Pharmacy announces that it will conduct examinations for licensure at Brookings on Tuesday, Wednesday and Thursday, June 5, 6, 7, 1951. Candidates for registration by examination must be grad-

uates from a four-year course in a college of pharmacy. Applications should be filed with the Secretary prior to May 6th 1951. Candidates who have taken the written subjects in former years, and who have completed their practical experience requirements, will be eligible to complete their examinations at this meeting without further application. At their meeting in Pierre, last week, the Board of Pharmacy adopted new regulations pertaining to the licensing of dealers in selected household remedies. These regulations will be announced at a later date.

The Rapid City Pharmaceutical Society held their regular monthly meeting February 6th at the Alex Johnson Hotel.

An excellent buffet dinner was served following which the guest speaker, Capt. W. S. Bragg of the Rapid City Army Air Force Base, discussed "Survival in an Atomic Bomb Attack. Capt. Bragg stressed the value of immediate and adequate first aid followed by proper care to keep the mortality rate low.

The proper procedures for keeping the radiation effects at a minimum were discussed at length, also, Capt. Bragg pointed out the necessity of maintaining adequate stock of first aid supplies to the pharmacists.

PRESCRIPTION REFILL CONTROVERSY

You have all read in your drug magazines of the controversy between the A. Ph. A. and the N.A.R.D. on the best method for correcting the Food and Drug Administration's holdings regarding the refilling of prescriptions. The N.A.R.D. advocate the passage of the Durham-Humphrey Bill which would legalize the refilling of all non-prescription legend drugs unless marked "not to be refilled. It would permit the use of the telephone on original prescriptions and refills, even for Rx-legend drugs if the physician signs within 72 hours. All that is good, but the FDA would be given the right to name all Rx-legend drugs and take this right from the manufac-

turer who may wish to have his product restricted to prescriptions. The A. Ph. A. proposed to solve the refill problem by way of regulations by the Federal Security Administration. The Proposed Order issued on December 6, 1950 by Oscar Ewing, Federal Security Administrator exempts prescription refills for the so called harmless over the counter drugs from the labeling requirements of the Act. It does not exempt Rx-legend drugs and pharmacists are warned again against selling any Rx-legend drug without prescription, or of refilling the same without a new written order.

NEWS ITEMS

The Luther Hospital Pharmacy in Watertown was closed on Jan. 1, and **Martin Wilkins** of Clark who was managing this pharmacy is now in the market to buy a drug store in a County Seat town. The Knutson Drug Store at Doland has been sold to a non-pharmacist who will operate as a sundries store. The Rolfe Pharmacy at Flandreau is now managed by **Donald Knutson** of Rapid City. **Walter Rolfe**, former owner died on November 11. The Olson San-Tox Store in Flandreau has been re-registered as a pharmacy since January 1st. Other permits to conduct a pharmacy for NEW drug stores have been issued to The Clinic Pharmacy, Madison, Hall's Drug Store, Sioux Falls and Andes Drug, Lake Andes. Pharmacist **James H. Dickey** died at De Smet Jan. 1. He was former owner of a drug store at Iroquois. Pharmacist **J. C. Huisinga** of Chancellor died Jan. 8. **Ludwig J. Faeth** a pharmacist of Aberdeen passed away on December 26th.

PHARMACY REFRESHER COURSE

Dean Floyd Le Blanc of S. D. School of Pharmacy announces a refresher course will be held again this spring. The dates are April 2, 3, 4. The program will be streamlined this year with registration on Monday from 1:00 to 1:30 and closing at noon on Wednesday. The program is not yet completed so watch your mail for complete details. Plan now to attend this important event; everyone who attended last year reports that it was well worth the time and effort.

The Junior and Senior students at S. D. School of Pharmacy are planning a trip to the Eli Lilly Laboratories, Indianapolis, Indiana, during their spring vacation.

Dr. Eugene Lewis, registered pharmacist of Lake Preston, was found dead in his bed in Des Moines on January 11. "Bud" was graduated from State Pharmacy School in 1936 and was at Cornwells at Webster and Kreislers at Sioux Falls previous to service in the Navy during the last war. After leaving the service he took osteopathic training at Des Moines and was interning at an osteopathic hospital at the time of his death.

(Continued from Page 73)

PNEUMONIA IN OLDER PERSONS

"Pneumonia" in a person past 45 may be the first sign of pulmonary carcinoma. Recurrent pneumonias over a period of 12 to 15 months indicates an underlying cause. Bronchiectasis, lung abscess or unresolved pneumonia is first diagnosed and only later is the obstructive cancer recognized.

A. Behnrend, M.D. Postgrad. Med. Jan. 1949.

— Edited by Don Manning, M.D., Sioux Falls.

ANNOUNCEMENT!

If you should change your address
please notify the Journal office—
300 First National Bank Building,
Sioux Falls, South Dakota.

Prescribe
Journal
Advertised
Products

Why Test Visual Fields?

P. J. Leinfelder, M.D.*

Although the delineation of visual fields is a common procedure in any ophthalmologist's office, the indications for the recording of the fields are not always clearly established, and variations in technics and methods add to the difficulties of examination and interpretation. It is apparent that visual field tests are made in order to determine the extent of the visual field. However, since this is not a routine test and the patient on whom the visual field is to be taken must be selected, the method of examination must be determined. Finally, careful interpretation of the results of the examination must be made.

The selection of the patient is one of the more difficult problems confronting us. There are several diseases when diagnosed or suspected that definitely call for delineation of the visual fields. However, in a large number of patients where diagnosis is not obvious some factor in the history or examination must suggest the desirability of the visual field test. There is no difficulty in appreciating the need for visual field studies in patients who are suspected or who are being followed for glaucoma, for in this disease the most valuable aid in formulating the diagnosis or in determining the degree of control is obtained from the study of the visual fields. However, in neuro-ophthalmological conditions such a definite indication is usually not present, and at times only the most vague clues exist. Therefore one is frequently asked, "When should visual fields be made?" or, "How does one know that visual fields are indicated on a patient in whom there are no clear-cut ophthalmological signs or symptoms?"

In the first place it is quite obvious that any patient who is referred by a neurologist should have a visual field test. Frequently the neurologist requests this when he recognizes in his patient the neurologic disease in which visual field changes may occur. However, if the patient has not been referred by

a neurologist, and if he is one of those who so frequently comes to our offices with complaints that may or may not be readily explained on ocular findings, we may miss an opportunity to make an exact diagnosis if we are unaware of the indications for visual field studies.

It is unnecessary if not impossible to do accurate visual field examinations on every patient who comes to our offices. However, there are circumstances under which recording of the visual fields becomes mandatory. The first of these is the circumstance of non-refractive diminished visual acuity in one or both eyes. Ordinarily this is further qualified by saying, "Visual acuity loss that is not understandable on the basis of ophthalmoscopic examination." However, any patient who shows a reduction in visual acuity, even if due to a retinal lesion, should have a visual field test in order to establish a basis that can be used as a comparison for changes that may occur within future examinations. This is especially true in cases of macular degeneration and detached retina or in cases of optic atrophy and neuritis. If the visual acuity is lost and cannot be improved by correcting lenses, there is adequate reason for suspecting some process that involves the visual pathway. This may be due to involvement of the optic nerve in neuritis due to multiple sclerosis, tobacco, alcohol, or other intoxications or nutritional deficiencies. Visual acuity can also be lost because of inflammation, degeneration, or tumor within the cerebrum which is destroying or pressing on the optic nerve, the optic chiasm, optic tract, or optic radiations. Determination of the extent of the visual fields will clearly indicate the presence or absence of such disease processes, and furthermore will give information concerning the nature and location.

In some events there are fundus changes that are indicative of neurologic disease, but which frequently are not accompanied by changes in visual acuity until late in the course of the affection. It is quite apparent

*Department of Ophthalmology, University of Iowa Medical College.

that the discovery of choked disc or optic atrophy makes it imperative that a record of the extent of peripheral vision be determined in order to ascertain whether or not the visual pathway has been involved in the primary disease process.

Finally we must be aware of those relatively silent processes which cause vague complaints that are not at all understandable on the basis of our usual examination. It is in those cases that the careful examination of the visual fields often establishes a diagnosis that might otherwise go unrecognized for a number of years. This is particularly true in the patient who complains of vague but persistent headaches, visual distresses and anomalies that are not recognizable on the usual examination, and which do not respond to treatment by changes of glasses or other local measures. Many patients with these complaints are suffering from pituitary tumors or other disease processes in the central nervous system, and not uncommonly visual field studies will uncover the pathologic reason for these rather vague and seemingly unexplained complaints.

In speaking of visual field tests, one is using a general term for a method of examination of the peripheral extent of vision that may be made in several different ways. First of all there is the confrontation test which is a gross method for determining advanced and absolute changes. For more exact records the perimeter is used to reproducibly delineate the peripheral extent of the visual field. The tangent screen determination in which small targets at greater distance reproduce the changes in the periphery when properly used gives the most accurate representation of visual field changes affecting the central area. Finally one may use the stereocampimeter. Each of these tests has its own indication and its limits of accuracy, and all are dependent on a number of factors: i. e., the patient, the examiner, the target, illumination and method used by the examiner.

The confrontation method is used only to obtain a rough estimate of the extent of the visual field. A considerably more accurate method for determining the extent of the visual fields and the only method that records the extreme peripheries is the perimeter test. Most examiners find peri-

metric tests rather cumbersome and time consuming, but it remains the most effective method for obtaining a true estimate of the absolute limits of the visual field.

The tangent screen method for estimating the visual fields is the one most commonly employed. The effectiveness of this method depends on the theory of isopters that was developed by Traquair. When a 1 mm. test object is used at a distance of one meter, the peripheral extent of visibility of this test object is 30 degrees from the fixation point. Since this is the true peripheral field for this size test object, any changes in the peripheral field are recordable within that 30 degree circle just as truly as they would be with a larger test object used on the perimeter to record the peripheral fields. However, the essential factor in tangent screen work is the realization that it is only the 1 mm. test object at a distance of one meter that satisfies the requirements for accuracy. If a larger test object is used and a 30 degree field is obtained, the results of the test are not valid and do not indicate absence of change. Careful use of the tangent screen allows one to obtain perfectly valid records of the state of the visual field that will show all types of change from concentric contraction to central scotomas, and from complete homonymous hemianopsias to partial quadrantic cuts in the bitemporal fields.

The final method utilizes the stereocampimeter. This instrument was devised primarily for evaluation of the central visual fields, and for the recording of central scotomas. It is particularly reliable and accurate in the patient who has a unilateral central scotoma. This is true because the stereoscopic arrangement allows binocular fixation while delineating the visual field on one eye. The use of the instrument for peripheral fields is not recommended since that application is not one for which the instrument was originally devised.

In every event the results obtained from testing the visual fields really depend on the size and quality of the test target. The quality depends upon illumination and color. Ordinarily only the white test object is used for recording the peripheral extent of the fields since nothing is gained by using a colored object that could not be demonstrated with a smaller white object. The red target

is used to demonstrate the presence of a relative central scotoma. Occasionally a blue target is used to outline the defect caused by local retinal disease.

The size of the target used is always the smallest one that can be recognized by the patient and will allow accurate work by him. For the perimeter best results are obtained when a 3 mm. test object is used. For the tangent screen accurate results are obtainable only with the 1 mm. test object, unless visual loss has been so extensive that the 1mm. test object cannot be seen. It is a gross error to consider that because the visual field can so easily be taken with a larger test object on the Bjerrum screen that such a field represents an accurate one. It must be understood that a 30 degree field obtained on the tangent screen with a 3 mm. test object does not represent the normal peripheral limits for the visual field with that target, since they extend out at least to approximately 50 degrees. Therefore up to 20 degrees of field could be lost but not recorded on that particular test. When using the stereocampimeter, the smallest targets available are utilized first. The larger targets are used to test the density of the scotomatous area.

Now we come to the question, "What does the best mean?" The validity and accuracy of a visual field test depends first of all on the patient. There is no question about the fact that in some instances the most reliable visual field that can be obtained is the confrontation test. This is because the intelligence, reliability and attentiveness of the particular patient will determine the accuracy of the results obtained. If a patient is sick, has a severe headache, and has difficulty concentrating because of fatigue or illness, we cannot obtain accurate visual fields. If the patient is unintelligent and cannot comprehend what we are attempting to do, the results will not be good. Therefore, every patient must be considered in terms of his ability to cooperate and the visual field that is obtained must be interpreted in terms of his ability to understand and report on his observations during the test. Many times repeated examinations are required to prove the accuracy of the test.

The technic used will alter the results of the test. The attitude of the operator will af-

fect the accuracy of the test. If the perimetrist hurries the test, the result will be less accurate than if he takes adequate time. However, a slow technic may so tire the patient that the result again becomes inaccurate. The operator must not use too much suggestion, yet he must continually prod the patient to report accurately and to maintain fixation.

It should always be borne in mind that any test of the visual fields must be made under circumstances that can be repeated, so that the record will show the type of test made, the target size and color used, and the distance at which the patient was seated. The illumination is kept standard, but if this was varied, it must be recorded. Any repeat field that is made under the the same circumstances can then be compared with the original or any other field. However, if a different method is used at subsequent examinations, no comparison is possible.

Study of the visual fields demonstrates graphically the visual capacity of the patient. Scotomatous defects outlined by the various defects indicate the site of diseased processes that are interrupting the visual pathway. Although several technics for examination are available, the most accurate and most generally used is the Bjerrum screen test. All methods of plotting the visual fields can be faulty because the test is dependent upon the attention and accurate observation of the patient.

ANNUAL MEETING

JUNE

3-4-5-6

ABERDEEN

South Dakota

Make Reservations Now

Committee on Trauma American College of Surgeons Rehabilitation of the Quadriceps*

"But, doctor, my knees feel so weak." That is the most common complaint after illness. The weakness is not, of course, "in the knees" but of the quadriceps muscle. It may be said that physical rehabilitation begins with the quadriceps. The purpose of this bulletin is to review the anatomy and function of this important mechanism in such a manner that it may serve for the instruction of medical personnel and patients.

The upright position of the body is maintained by the tonus of the antigravity muscles, essentially the gluteus maximus, quadriceps and gastrocnemius-soleus, without which the lower extremities tend to collapse. The most important and most common site of instability is the knee joint. This joint is essentially a hinge which can collapse in only one direction, namely flexion, since lateral motion and extension are limited by the contour of the bones and the stability of the ligaments. Except for unusual factors such as hyperextension deformity or fibrous ankylosis, only the quadriceps muscle keeps the knee from giving away in flexion. In addition to maintaining the erect position the quadriceps has the more active function of extending the knee in walking and of lifting the body weight in arising or climbing steps.

The quadriceps, as its name implies, is a composite muscle of four origins and a common insertion. Only the rectus femoris arises from the pelvis where it is attached by two heads in front of and above the acetabulum. The other three muscles, vastus lateralis, intermedius and medialis, arise from the lateral, anterior and medial aspects of the femur. The four muscles merge to form the quadriceps tendon, which contains the patella,

and then continue on as the patellar tendon which inserts into the tibial tubercle. Except for the hip flexion produced by the rectus femoris, the action of the quadriceps is solely that of extending the knee; or, as indicated above, of keeping the knee in extension under load while the individual stands. With the knee in full extension the minimum effort is required for standing; therefore it is important that the angle of full extension be jealously guarded in all conditions where muscle power or — joint motion might be lost. The nerve supply of the quadriceps is the femoral nerve, fortunately seldom subjected to injury, but unfortunately its cells of origin are often involved in diseases, particularly poliomyelitis.

Any illness or operation which confines a patient to bed leads to rapid atrophy, loss of tone, or deconditioning of the quadriceps. When walking is resumed there is, therefore, a lack of confidence and security best expressed as "weak in the knees." Ascending and, particularly, descending stairs require care or assistance. Elderly people may find it difficult to regain this lost strength and are prone to fall, and incur serious injuries. A few brief periods of daily exercise or reconditioning prevent this atrophy and provide a valuable safeguard. Exercises which are productive or competitive are more interesting but the patient soon grasps the importance of these less interesting static "muscle setting" or active exercises. At the same time other muscles must participate and benefit by the exercises. Finally the benefit to circulation and general nutrition should not be underestimated.

The strength of the quadriceps has direct relation to trauma or disease involving the knee joint. After severe trauma or surgery about the knee, the quadriceps suffers almost a complete temporary paralysis due to some reflex mechanism. Re-education and re-development of the muscle are the single most important part of rehabilitation after injury or surgery. Diseases such as arthritis cause atrophy of the quadriceps and fre-

*Note: This is the second in a series of articles on rehabilitation and is the first on a specific problem. This material was prepared by Leonard T. Peterson, M.D., F.A.C.S., Washington, D.C., who is a member of the Subcommittee on Rehabilitation, of which A. William Reggio, M.D., F.A.C.S., Medfield, Massachusetts, is Chairman. It is distributed by the Committee on Trauma, American College of Surgeons, through its Regional Committees on Trauma.

quently lead to flexion deformity because of this weakness as the flexors exert stronger pull than the quadriceps or extensor. The synovitis which follows an injury or disease often persists until the muscle has regained its strength. Unless active rehabilitation measures are taken the disability becomes chronic and even permanent.

What then can be done to preserve or regain the power of the quadriceps muscle? While physical rehabilitation has many other aspects, this subject is one of the most important and serves as a good starting point. Quadriceps training requires no special apparatus or skill. Let us itemize a few essential details.

1. The attending physician must bring rehabilitation to the bedside. He must be aware of its importance and be willing to devote a minute or two during his daily visit to the instruction of the patient.

2. The patient should be told that **he alone** can exercise his muscles. Massage or mechanical devices **cannot** develop strength. The impulse starts in his brain and follows the nerve pathway to the muscles. Strength is attained only by active exercise. Periods of instruction or clinic treatment are only training for the work the **patient** must perform between visits.

3. Factors limiting the intensity of exercise are essentially (a) pain and (b) fatigue. The patient seldom exercises beyond the limit of either and he may safely exercise if he experiences neither excessive pain nor fatigue.

4. The knee should be in extension during most of the time while at rest. Especially after trauma or surgery involving the knee is this important. The patient who lies for even a day or two with his knee flexed over several pillows will have to spend considerable time and effort regaining extension.

5. Exercise should be started as soon as possible after the patient is confined to bed and within 24 hours after surgery or trauma.

6. Exercises may be classified as (a) static, (b) passive, (c) assistive, (d) active, and (e) resistive.

(a) Static exercise means contraction in situ, isometric contraction, or contraction without joint motion. It is performed with the knee in **extension** by (1) pulling the patella up (2) by pressing the knee down or (3) by simulating the motion of lifting the

heel off the bed.

(b) Passive exercise, which is motion carried out by the therapist, is not true exercise and is usually not indicated as there is no voluntary muscle contraction.

(c) Assistive exercise is active plus passive exercise, and is helpful in the early stages of rehabilitation.

(d) Active exercise is entirely voluntary contraction, usually against gravity only.

(e) Resistive exercise is voluntary contraction against manual or weight resistance.

Exercises — static, active, and resistive — are progressive in that order. A type of exercise which does not attain full knee extension is ordinarily too advanced and should not be used. For example, if the patient cannot hold the leg fully extended against the force of gravity, he should not attempt to lift the leg but should be limited to static exercise. If he cannot lift weights and fully extend the knee, he should be limited to active exercise with only the weight of the leg.

Exercise to be effective must be strong, intermittent, and interrupted by a brief period of relaxation so that the muscle may recover by receiving nutrition and oxygen, and by eliminating waste products. A muscle held in a prolonged state of contraction tends to fatigue and atrophy. The best method of relaxing a muscle is to contract the antagonist muscle or, in the case of the knee, to flex the knee slightly between each exercise. The patient is advised to perform a complete cycle "contract — hold — relax — rest" about eight times a minute. Thus in five minutes he can perform 40 complete cycles — a good goal **for every hour** while in bed or sitting up so as to get ready for walking.

After the patient can straighten the knee and hold the leg against the force of gravity, active exercise is indicated. He may lift the leg actively from the bed or, while sitting, actively flex and extend the knee over the edge of the bed or table — always to full extension. Finally, increasing resistance is added by weights attached to the foot. While repeated exercises develop endurance, strength is developed by a few exercises daily with the maximum weight which can be lifted effectively. Particular emphasis should be placed on development of the vastus med-

(Continued on Page 94)



PRESIDENT'S PAGE

L. J. Pankow, M.D.

April Letter

For the first time in my memory the South Dakota State Medical Association can relax after a Legislative Session and not have to lick its wounds. Every Bill which was introduced at the request and with the approval of the Council was passed. Most of the Bills which the Council endorsed were enacted into legislation, and most of those to which we objected, were defeated. This is a most enviable record for which no one officer or member of the Association may take exceptional personal credit, for it was done by all Officers

and Members working together for the best interests of our Profession, our Association and for the Public Good.

There were a few disappointments which we must accept, but none are irreparable losses. The increase of limits of medical and hospital liability under workmen's compensation, while not as great as we had hoped, is definitely an improvement over the slap which we received at a previous session. I consider the fact that Organized Labor and our Profession joined forces on this matter establishes a precedent which will work for the benefit of both organizations. It may dispel some of the suspicion with which some Labor Leaders have too often viewed us, and will help us to better understand the problems and aims of workers. This is proper, for the physician is no more than a highly trained person making his living with his hands and knowledge.

Bills were introduced which were directed at the Advisory Committee of the State Department of Health, first to abolish it, then to replace one member by a member of the State Nurses Association, and lastly, to remove supervision of the State Old Soldier's Home and the T. B. Hospital, Sanator, from the Board of Health and place it under a new committee. Our efforts prevented the abolishment of the Advisory Committee, and our support secured a place on the Committee for a representative of the State Nurses. Perhaps the interest that was shown by our Association in this matter may stimulate the Advisory Committee AND the State Department of Health to a greater and closer cooperation in the future.

It was not with our approval or disapproval that a new committee was created to supervise the State Soldier's Home and Sanator. I believe that these two institutions are public health matters, and as such, should be under the direction and supervision of the State Department of Health. The convictions of the Governor and many other leaders, however, pointing out apparent neglect of these two institutions by the Department of Health and the Advisory Committee, and the Soldier's Home Board, secured enactment of a law creating a new committee, smaller in number, whose responsibility is for these two places only. This committee will include at **least** one Physician to be appointed by our Governor from a list of nominees from our Association. I feel confident that the excellent judgment of our Governor can be depended upon to name interested and well qualified persons on this new and important committee. So, despite the bitter disappointment of certain medical areas over this legislation, now that it HAS become law, I am sure that we as an Association and as Individuals will watch development and progress with helpful interest. It is possible that this may be for the best interests of the public welfare and for these establishments.

For a complete report on the disposition of all matters that affect medical interests I direct you to the account of the Executive Secretary, elsewhere in this issue. Mr. Foster served in the 1951 Legislature as a Representative from Minnehaha County. His election relieved the Association of the expense of keeping him in Pierre during the Assembly.

In my opinion it is excellent that the Executive Secretary of the South Dakota State Medical Association could be nominated and elected to the Legislature from the most populous County of our State. Perhaps more Doctors of Medicine should seek a direct voice in Legislation in the future, not for personal or professional benefit, but for the public benefit.

EDITORIAL PAGE

NEW INSURANCE ENDORSEMENTS

The South Dakota Injury-Illness Expense Plan, written by one insurance company since 1946, has recently had its face lifted. The original plan, which had to be written exactly as agreed upon by the Association and the insurance company was modified by action of the House of Delegates last year to provide for approval of policies including "similar benefits and premium charges."

The Paul Revere Life Insurance Company has met the requirements for approval and is now selling a non-cancellable policy that carries the endorsement of the South Dakota State Medical Association.

As before, it is well for all members of the Association to push the sale of the two approved policies. Only by providing adequate protection against the costs of medical care can the medical profession expect to hold the line against socialistic medicine.

GULLIBLES TRAVELS

Gullible, embroiled in the dying days of the legislature, managed to attend a meeting of the Pierre District Medical Society at the invitation of its president, **Dr. I. R. Salliday**. This was February 28, the day after I raced the stork to Sioux Falls to welcome a daughter into the Foster household.

On Tuesday March 6, I attended the Sioux Falls District meeting and reported on legislative activities.

The next night found me in Aberdeen at their District meeting to discuss legislation and also plans for the annual meeting. The group elected **Dr. P. V. McCarthy** general chairman for the event.

In Sioux Falls until March 15, when I drove to Vermillion to discuss legislation with the Yankton District Society. **Dr. Warren Anderson** of Sioux Falls spoke on Menengitis.

Tuesday, March 20, I was supposed to speak at a Rotary meeting at the invitation of **Dr. W. H. Patti**, Brookings. Heavy snow cancelled that as well as a visit to Watertown District that evening.

REVIEW OF STATE LEGISLATION CONCERNING THE MEDICAL PROFESSION—32nd BIENNIAL SESSION

The South Dakota State Medical Association sponsored five bills — a sixth on an annual registration fee for physicians was not introduced — and of these five, only one was defeated.

Those bills sponsored by the Association and results follow:

S. B. 159 provided that dogs and other small animals left in city pounds over 5 days could be requisitioned by schools of higher learning which have been approved by the Department of Health for research use. Passed Senate and House with few dissenting votes.

H. B. 66 provides that a coroner may order an autopsy when wrongful death is suspected — also provides for persons ordering an autopsy. Bill was held in committee for some time and phraseology changed from "in the public interest" to "on suspicion of unlawful means."

H. B. 92 provided for no limit on medical, surgical, and hospital benefits. Finally passed, amended, to set limits of workmens compensation at \$700 for hospital services, \$300 for physicians services. Passed.

H. B. 163 provides \$203,000 for equipping new medical school building at the University. Association recommended \$216,000 which was cut to \$203,000 by joint appropriations committee. Passed House — killed, then reconsidered in Senate and passed.

H. B. 361 concerned who may use the term "doctor." Bill was lost in house.

Three bills were given approval by the Council of the State Medical Association:

S. B. 71 provided for \$800,000 to build a hospital for senile patients at Watertown. Killed in the Senate.

H. B. 82 provided for \$17,000 for Mental Health Division of the Department of Health. Passed House but was defeated in Senate.

Was subsequently "hog-housed" and became law.

H. B. 120 provided \$300,000 for a new hospital building at Sanator. Passed.

(Continued on Page 94)

This is



APRIL
1951
Vol. 4 No. 4

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Guest Speakers To Be Heard At Annual Meeting, June 4-5-6



NEUROLOGICAL SURGEON SPEAKS ON HEAD INJURIES

Roland M. Klemme, M.D., neurological surgeon of St. Louis will be featured on the Wednesday Annual meeting program June 6 with a paper on "Head Injuries."

Dr. Klemme in addition to his private practice is Professor of Surgery, chairman, Division of Neurosurgery at the St. Louis University School of Medicine. He is also affiliated with the University of Missouri School of Medicine and is consulting neurosurgeon for the Missouri Pacific, Frisco, Wabash and M-K-T railroads.

He is the author of numerous papers, has published a

book on "Nursing Care of Neurosurgical Patients" and has two more in preparation. Two color films in sound bear his name and he inaugurated the medical film library of the Library of Congress, Washington, D. C.



Photo by Fabian Bachrach

G. P. ACADEMY EXEC. ON S. D. PROGRAM

Mac F. Cahal, executive secretary of the American Academy of General Practice will be a featured speaker on the third day of the scientific program of annual meeting of the South Dakota State Medical Association. His topic will be centered on the work of the general practitioner.

Mr. Cahal is a graduate of DePaul University of Law and has been executive secretary of the Sedgewick County Medical Society (Wichita, Kansas) executive secretary of the American College of Radiology, executive vice-president of the Southwestern Medical Foundation in Dallas, and took on his present duties in 1948 with the Academy.

He is managing publisher of G. P. and was the founder and first president of the National Association of Medical Society Executives.

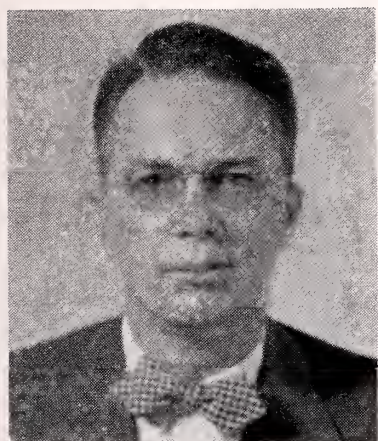


THOREK TO PRESENT TWO SURGICAL PAPERS

Philip Thorek, M.D., Chicago, will present two papers at the Annual Meeting in Aberdeen, on Monday, June 4. His morning presentation will be titled "The

Acute Abdomen" and his afternoon paper, "Intestinal Obstruction."

Dr. Thorek is Clinical Assistant Professor of Surgery, University of Illinois, Associate Professor of Surgery, Cook County Graduate School of Medicine; Chief Surgeon, American Hospital; Attending Surgeon, Cook County Hospital; and Attending Surgeon, Alexian Brothers' Hospital.



**ROBERT E. PRIEST, M.D.
TO PRESENT PAPERS ON
TRACHEOTOMY**

Dr. Robert E. Priest, ear, nose and throat specialist of Minneapolis will speak on "Tracheotomy and Bulbar Poliomyelitis" on the Monday afternoon session of the South Dakota State Medical Associations 70th Annual Meeting.

Dr. Priest practices in Minneapolis with emphasis on bronchoscopy, esophagoscopy and laryngeal surgery. He is Clinical Assistant of Ear, Nose, and Throat at the University of Minnesota and Chief of the Ear, Nose, and Throat Service at Minneapolis General Hospital.

**A. L. HOYNE SPEAKS ON
CONTAGIOUS DISEASES**

Archibald L. Hoyne, M.D., Chicago, will present a paper on, "Eruptive Diseases of a Contagious Nature" on the second (medical) day of the



Annual meeting in Aberdeen.

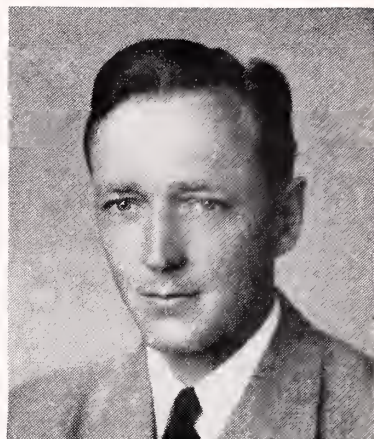
Dr. Hoyne is Professor of Pediatrics, Chicago Medical School; Clinical Professor Emeritus of Pediatrics, University of Chicago; and Clinical Professor Emeritus of the University of Illinois.

He is Chief, Department of Contagious diseases, Cook County Hospital; Head Pediatric Department, St. Joseph's Hospital; and Attending Physician, Children's Memorial Hospital.

**DR. PRUITT OF MAYO
WILL DELIVER CARDIAC
CARE PAPER**

Dr. Raymond D. Pruitt, internist from Mayo Clinic will present a paper on "The Medical Care of Cardiac Patients Undergoing Surgery" on Tuesday June 5 at the Annual Meeting.

Dr. Pruitt is a graduate of the Kansas University School of Medicine, a Fellow of the Mayo Foundation and a Dip-



lomite of the American Board of Internal Medicine.

**SPEAKERS AVAILABLE
FOR DISTRICT MEETINGS**

Forming a nucleus for the new speakers bureau of the South Dakota State Medical Association are the speakers and their subjects listed below. Additional speakers will be listed in the Journal in the near future as they are received in the Association office. A cross-index of speakers and subjects will also be maintained.

Available now are:

1. B. T. Lenz, M.D., Huron; **Diagnosis and Management of Poliomyelitis.**
2. C. F. Gryte, M.D., Huron; **Differential Diagnosis of Chest Pain.**
3. H. L. Saylor, Jr., M.D., Huron; **Surgical Indications in Gall Bladder Disease.**
4. H. L. Saylor, Sr., M.D., Huron; **Diagnosis and Management of Injuries of the Eye.**
5. W. H. Saxton, M.D., Huron; **Indications for a Hysterectomy.**
6. Paul Tschetter, M.D., Huron; **Indications for, and Preoperative and Postoperative Management of Tran-**

surethral Prostatectomy.

7. Roscoe Dean, M.D., Wessington Springs; **The Management of Poliomyelitis-Comparison of Orthopedic and Sister Kenny Treatment.**

8. Ranney, Brooks, M.D., Yankton; **OB & Gynecology; Endometriosis; Hemorrhage in late Pregnancy; Infertility; Early Ca. of Cervix; Ovarian Cysts & Tumors.**

9. Sattler, T. H., M.D., Yankton; **Internal Medicine; Cardiac Disease; Jaundice & Liver Disease; Duodenal Ulcer (combined Symposium with Dr. McVay.)**

10. McVay, C. B., M.D., Yankton; **Surgery; Hernioplasty; Duodenal Ulcer (combined with Dr. Sattler); Rx Burns; Chronic Appendix; Massive gastrointestinal Hemorrhage; Abdominal Incisions.**

11. Livingston, R. F., M.D., Yankton; **Urology; Kidney Incisions; Hematuria; Urinary Infections; Prostatism; Pediatric Urology.**

12. Willcockson, T. H., M.D., Yankton; **Recent Advance in Ocular Therapeutics.**

13. Haas, F. W., M.D., Yankton; **Mental Diseases.**

14. Williams, D. B., M.D., Yankton; **Mental Diseases.**

15. Steele, J. P., M.D., Yankton; **Radiology.**

PIERRE DISTRICT REVIEWS LEGISLATION

The Pierre District Medical Society met at the Falcon Cafe in Pierre and at the Pierre Clinic to eat and to hear a report on State legislation by Association executive secretary **John C. Foster.**

The meeting was concluded with a business ses-

sion. **Dr. I. R. Salliday** presided at the meeting.

YANKTON DISTRICT HEARS W. R. ANDERSON

Dr. Warren R. Anderson, Sioux Falls pediatrician was the speaker at the regular meeting of the Yankton District Medical Society held in Vermillion on March 15. The subject of **Dr. Anderson's** paper was "Meningitis."

The members of the Auxiliary met with the Society members for dinner at the Congregational Church and then held a separate business meeting.

SEVENTH DISTRICT HEARS KIRTLEY

Dr. J. Kirtley, Indiana University Medical School, and the Eli Lilly Company, presented a paper on "Diabetes and M.P.H. Insulin" at the regular monthly meeting of the Seventh District Medical Society at the Cottage in Sioux Falls on March 6.

Dr. Donald Breit, president, presided at the meeting which included a business session. The society heard a report of legislative activities by the State Association's executive secretary and voted to support a mental health clinic in Sioux Falls.

DR. R. H. McBRIDE HEADS S. V. ASSN.

Dr. R. H. McBride of Sioux City was elected president of the Sioux Valley Medical Association at concluding sessions of the organization's 55th annual meeting here.

Other new officers are **Dr. Walter Wells** of Jackson,

Minn., vice-president, and **Dr. Ronald Barr** of Sioux Falls, S. D., treasure. **Dr. E. H. Sibley** of Sioux City was re-elected secretary. **Dr. McBride** succeeds **Dr. Wayne Benthak** of Wayne, Neb.

Sioux Falls was named as the site of the association's 1952 meeting.

POSTGRADUATE COURSE IN ALLERGY

A postgraduate course in allergy will be offered by the American Academy of Allergy on June 14, 15, and 16 in Montreal, Canada. It will be sponsored by the Faculty of Medicine, McGill University and will be held at the Royal Victoria Hospital in Montreal.

Any interested physician in the United States or Canada may attend. Fee for the course is \$40. Applications can be sent to **Bram Rose, M.D.,** Royal Victoria Hospital, Montreal 2, Canada.

CHEST PHYSICIANS MEET JUNE 7-10

The Seventeenth Annual Meeting of the American College of Chest Physicians will be held at the Ambassador Hotel, Atlantic City, New Jersey, June 7 through 10, 1951. An interesting scientific program has been arranged for presentation at the meeting.

The Board of Examiners of the College has announced that the next oral and written examinations for Fellowship will be held in Atlantic City on June 7. Candidates who would like to take the examinations for Fellowship

should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The Convocation ceremonies will be held at the Ambassador Hotel, Atlantic City on Saturday, June 9, at which time Certificates will be awarded to new Fellows of the College.

Dr. William L. Meyer, Sanator, serves as Governor of the College for South Dakota.

B. B. LEONARD, M.D. 1901 - 1951

Dr. B. B. Leonard, Yankton E.N.T. specialist, passed away March 28 at his office. Death was caused by a heart attack.

Dr. Leonard was born July 11, 1901, and was graduated from the University of Iowa Medical School. He practiced briefly in Iowa before locating in Yankton in 1933.

Dr. Leonard is survived by his father, B. B. Leonard, Sr., M.D., of Anthon, Iowa, and a sister, Mrs. Finley McGrew of Chicago.

S. F. TUMOR CLINIC BEGINS OPERATION

The new Sioux Falls Tumor Clinic is now holding weekly meetings at the City Health Department. The clinic will meet each Thursday at 10:30 a.m. and is operated cooperatively by the Cancer Society and local physicians. The clinic is a consultation service and patients are to be seen only when referred by a physician, and will, in turn, be referred back to the physician. All reports, findings, and recommendations will also be sent directly to the physician.

MICHAEL REESE HOSPITAL ANNOUNCES POSTGRADUATE COURSES

The Michael Reese Hospital of Chicago has announced spring and summer postgraduate courses starting in April and running through July.

The first course one week in length is on "Clinical Dermatology" and starts April 2nd. Surgery starts and ends April 14th. "Recent Advances in Internal Medicine" starts April 30th through May 12th. "Recent Advances in Pediatrics" starts May 21st through May 26th. "Diseases of the Endocrines" begins July 9th and ends July 21st. "Hematologix Diagnosis" begins July 23rd and ends August 4th.

Detailed schedules may be obtained by contacting Michael Reese Hospital, 29th Street and Ellis Avenue, Chicago 16, Illinois.

FREDERICK DeVALL, M.D. HONORED APRIL 8TH

Dr. Frederick DeVall, veteran practitioner of Garretson for the past forty-six years, was honored at a community gathering in the Garretson Community Hall, Sunday, April 8. A musical program was given and a series of talks by local dignitaries and visiting physicians. The remainder of the afternoon was an informal get-together followed by a lunch.

The affair was sponsored by the Garretson Community Club and arrangements were made by E. O. Tandberg, Dr. E. E. Suckow, T. E. Wangness, Paul Lubke, Hector DeSchepper, and David Erickson.

MEDICAL SCHOOL RECEIVES U.S. GRANT

A \$5,000 grant to the Medical School at the University of South Dakota from the U. S. Public Health service will become effective May 1, according to Dr. H. N. Carlisle, chairman of the department of Microbiology at the University.

According to Dr. Carlisle, "the funds will be used to support a research project concerning the application of a recently developed diagnostic technique to the detection of brucellosis (undulant fever) and other diseases of man and animals."

The grant was obtained by application to the United States Public Health Service and is being made to the University Med School, with Dr. Carlisle the chief investigator.

NEWS NOTES

The city of Faulkton held open house March 29 for the new Community Hospital. Rev. Arthur A. Schade, formerly of Huron, is the manager. The old hospital building will be converted into a home for the aged at a later date.

Doctor Edward A. Holyoke, professor of anatomy at Nebraska University, recently completed a ten-day session at the University of South Dakota as an exchange professor. This marked the first time an exchange professorship had been arranged between the University of Nebraska Medical School and the South Dakota Medical School.

The Medical School of the University of South Dakota held its Fourth Annual Dinner Dance in Julian Hall Saturday, March 31.

PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor

Putting the "Farm Assist" in the Animal Health Department

By - W. N. Stebbins

Sharpe & Dohme

The drug business has set some new volume-records so far during the year 1950 and quite possibly a speaker's suggestions for achieving an increased volume might well be regarded as an attempt to "guild the lily." So, let me put your minds at ease right here at the start — it is quite unlikely that there will come from my lips any pearls of wisdom that can be converted easily into greenbacks and rung up on the cash register. On the other hand, I have no intention of standing up here wasting your time and my own if I can help it; and, so I will try to contribute some ideas and information that in the long run should make your stores more helpful and attractive to animal health customers. It's the familiar service angle which, of course, squares with the idea that where service is rendered, business is done. Furthermore, it is well to bear in mind that any contributions we may be able to make by way of improvement of animal health adds to our country's economic strength. A large portion of our every-day food — milk, meat, eggs cheese, butter, etc. — is of animal origin. Helping reduce the rather high mortality rate of young farm and ranch animals might well be considered a duty.

It has never followed that because an idea might be basically sound or a product definitely valuable — John Q. Public would automatically consider it acceptable. Your success, then, in introducing improved veterinary medicinals will hinge to quite an extent on your persuasiveness. What follows here are really some fundamentals of selling,

but if these fundamentals are not being observed, you are doing your persuading the hard way.

Start by making the farmer or rancher feel welcome and greet him with a friendly smile and by name. If he is a stranger to you, ask him what his name is somewhere during the interview. That's simply basic sales psychology and an effective but completely legal kind of flattery. Introduce yourself, too, so he doesn't have to stand around feeling like the speaker at some convention. Remember, too, that these farm people are especially allergic to the rush treatment as you, of course, know; so encourage them to talk and ask them a few questions. It will put you both at ease and greatly increase the likelihood of your coming up with the right answers to their questions. There is a great deal of basis for tension in the animal health department: The customer is more than a little wary about being sold something that won't work, and the druggist is a little jumpy for fear he's going to be dis-emboweled with a technicality. Don't attempt to be what you are not — a qualified veterinarian. You and your customer both know your limitations and a frank admission on your part that you're out over your head isn't going to lose you any business. There are a good many pharmaceutical and biological answers — yes, and a number of therapeutic and diagnostic facts, too — which you will do well to know very thoroughly. Among these are doses, means of administration, techniques, nomenclature, precautions, seasonal aspects of vaccines, limitations of protection, storage peculiarities, etc. I think we can take it for granted that these are, for the most part, technicalities with which you are al-

An Address delivered before the Annual Convention of the South Dakota State Pharmaceutical Association in Sioux Falls — June 14, 1950.

ready familiar.

One other thing that does a great deal to enhance the drawing power of the animal health department is a practical familiarity with the new developments in veterinary medicines. Many farm and ranch people are constant readers of farm and stock magazines which keep their patrons well posted on modern methods of animals treatment. Your own veterinary department will be evaluated to some degree at least by the manner in which you do or do not keep up to date. There is only a short lag period these days from the time a "miracle" drug appears in human medicine until it's finding application in the animal health field. Some, like our own Sulfathalidine, were veterinary releases first. The commercial lyophilization of live vaccine was first introduced for animal use. I'm referring to Lyovac Brucella Abortus Vaccine here. Since this process and the vaccine are receiving increasing approval, I'm going to bring you up to date on the most recent developments in the Bangs disease field.

To begin with, a report by a special committee of the United States Livestock Sanitary Ass'n. states that the animal loss due to brucellosis to the livestock industry is in the neighborhood of \$100,000,000. The loss of value of infected cows plus the loss of calves totals \$37,000,000 in itself. That's per year! Under the circumstances, it's a little difficult to rationalize the pre-occupation with cost of vaccine over quality that is occasionally encountered. Here's what can be expected in cattle properly vaccinated with Strain 19 Brucella Abortus Vaccine:

"Field trials indicate that cattle vaccinated as calves with Strain 19 vaccine remain resistant for 3 to 5 pregnancies. During the year supporting evidence was obtained from controlled experiments. Two groups of cattle, vaccinated as calves, had been maintained with suitable controls in separate fields for 4 and 5 pregnancies, respectively, at the time they were each exposed to 30 million virulent Brucella abortus organisms by way of the conjunctiva of the eye. In the fourth-pregnancy groups, composed of 19 principals and 8 controls, 16 (84.2 percent) of the vaccinated animals withstood the same degree of artificial expose that resulted in active

infection of all 8 of the unvaccinated controls. In the fifth-pregnancy groups, composed of 10 principals and 5 controls, similarly exposed, 9 (90 percent) of the vaccinated animals were protected against an exposure that caused active infection in all 5 controls. Under the conditions of these tests, the results indicate that Strain 19 vaccine, when fresh and properly administered may be expected to provide a high degree of resistance for 5 to 6 years following vaccination during calthood." Copied from the Report of the Chief of Bureau of Animal Industry, 1946, U. S. Department of Agriculture, Agricultural Research Adm.

(Recapitulation)

Results of experiments when cattle vaccinated as calves with Strain 19 and challenged in 4th and 5th pregnancy.

Fourth Pregnancy		
19 vaccinated 8 controls	challenged with 30 million organisms	Results 3 or 15.8% aborted 8 or 100% aborted
Fifth Pregnancy		
10 vaccinated 5 controls	challenged with 30 million organisms	Results 1 - 10% aborted 5 - 100% aborted

Taken from Report of the Chief of the U. S. Bureau of Animal Industry, 1946, page 34. All right, now what about the lyophilized vaccine! In controlled experiments such vaccine could be stored at room temperature for 22 months before the viable count fell below 10 billion organisms per cc. With that kind of evidence the Government has 'Lyovac' Brucella Abortus Vaccine as compared to a 3 months dating on liquid vaccine. This is interesting too: Our lyophilized brucella vaccine showed constant viable counts of over 20 billion organisms after restoration to the liquid state. These counts were maintained at the 20 billion level for over one month when maintained under refrigeration.

A bulletin published last year by the U. S. Livestock Sanitary Association states that there is no known cure for brucellosis in domestic animals. The erratic course of the disease in herds and in individual animals leads to misinterpretation of results obtained from any treatment that may be used. Occasionally animals recover spontaneously over a long period of time. Many animals discontinue showing active symptoms but usually are still diseased and are dangerous

sources of infection to other animals and man. Vaccination, says the Association, cannot be depended upon to halt threatened abortion "storms" in adult animals because the resistance builds up slowly as in the natural disease. Animals vaccinated as adults are mostly resistant, but there is a strong tendency for reactions to persist. Since vaccination reactions are as yet indistinguishable from reactions due to natural expose, adult vaccination can complicate the management of accredited herds and with other plans for brucellosis eradication.

A discussion on Animal Health must always include at least a few paragraphs on Mastitis. Styles in treatment of this disease have changed almost as much and as radically in the past ten years as have women's skirts. The current "new look" consists of the most recent miracle drugs packaged in ointment and/or emulsion form. Whether today's approach will out-sell the offerings of the past remains to be seen. As for the eradication of Mastitis — let's you and I have a heart to heart talk.

Mastitis is not in the same category as de-horning or putting a ring in a bull's nose or braiding a horse's tail for the county fair. Mastitis is a disease entity in which a relatively large number of factors must be considered if real and lasting improvement is to be achieved. The main consideration are these:

1. Proper methods of hygiene and cleanliness.
2. Nutritional considerations—correct feeding for health as well as milk production.
3. Avoidance of over-exercise — cattle should not be walked long distances, nor should they ever be forced to run. "Dogging" cows is often done and is invariably bad.
4. The mechanics of milking are an extremely important consideration. Some types of mechanical milkers are too rough and there have been instances where stripping is too forceful.
5. Both the acute and chronic stages should be considered and on a herd-wide basis. Acute mastitis responds quite satisfactorily to several of the sulfonamides administered either orally or by instillation into the udder. Penicillin injected parenterally or infused is also good. Combinations of sulfonamides in solution (sulfamerazine and sulfamethazine) with

penicillin and streptomycin are especially good where both gram positive and gram negative organisms are present. There is much evidence that Tyrothricin Veterinary is still the number one treatment for chronic mastitis. Twenty cc. of the preparation infused into each quarter after the last milking before the "drying off" stage should be routine in herds having a history of mastitis.

If you can get your farm customers to regard this mastitis proposition in its proper perspective, you will have rendered a real service. Cleaning up the disease, and the cause, on a herd-wide basis is the best way by far.

Farmers and ranchers impress many observers as being about the most deliberate class of people there is. They **are** deliberate too, but that doesn't mean their time isn't pretty valuable. Let's see — 60 hours a week, 2 wks. vacation a year — \$15,000 net — yes, that's about \$5.00 per hour. He'd make an expensive pharmacist, wouldn't he! Well, at \$5.00 per hour any rancher is going to be interested in the new triple vaccine for hemorrhagic-septicemia, black leg, and malignant edema. This triple vaccine is indicated for both cattle and sheep. The alum treated feature of the product delays absorption and, thus, prolong the antigenic stimulation. Active immunity develops in from 10 to 14 days.

We invariably think of farm animals when animal health is being discussed, but I would like to get a plug in here for dear old Rover. He may dampen the enthusiasm of your prize shrubbery, but he's the darling of the home and hearth, and modern medicine has not passed him by. No sir! Fido is mighty well regarded by his immediate family, and you will do well to stress quality, safety, and comfort when discussing remedies for His Honor. For instance, a combination of benzyl-benzoate and tyrothricin has been highly satisfactory for many kinds of pruritis and gives prompt safe relief of the itching. This is marketed under the name 'Tyroscape' and can be applied easily with a dropper. It's not for cats, incidentally, as they lick themselves and are too apt to get an over-dose of benzyl benzoate.

A recently marketed tapeworm tablet is some good news for dogs. It is far and away the best teniacide yet released, and you who dislike all these fancy commercial names will be interested in knowing that the drug is

called, 2, 2'-dihydroxy-5, 5' dichlorodi-phenyl-methane. Others may prefer to employ the name 'Belcest.' 'Belcest' is effective in single doses; has a prompt killing action on tapeworms; special treatment of dogs such as fasting is not required; and 'Belcest' has a very wide margin of safety. Oh yeh! and it has a very wide margin of profit. Even a dog couldn't ask for more than that! Thank you.

DRUGGIST IN WATERTOWN AREA MAKE PLANS TO ENTERTAIN S. D. PH. A. CONVENTION

Secretary Wilson met with the druggists in the Watertown area on March 4th at which time a tentative program was arranged. Local Secretary, Loren F. Thomes announced the appointment of Committees. The registration desk will be in the lobby of the New Grand Hotel and it will be open from 8:00 a.m. on Tuesday, June 12th. The First General Session will be held Tuesday morning. A picnic is planned at Lake Kampeska for Tuesday afternoon and the Allied Drug Travelers will be invited to entertain the Convention at a Mixer Party on Tuesday evening. The organization meeting of the Commercial and Legislative Section was planned for Wednesday morning, June 13th. This to be followed by speakers for the balance of the forenoon and afternoon. The annual banquet and dance are scheduled for Wednesday evening. The Final General Session will be held on Thursday, June 14th. Hotel reservations may be made now at the New Grand Hotel, Kampeska Hotel or Lincoln Hotel.

U. S. P. XIV AND N. F. XIII REQUIRED BY JULY 1ST

Our South Dakota Pharmacy Law provides that every registered pharmacy shall have on file the latest United States Pharmacopoeia, the National Formulary and supplements thereto. Both the U.S.P. XIV and the N.F. XIII are now official. If you do not have these latest editions on file in your pharmacy, they should be ordered promptly from your wholesale druggist. The Board of Pharmacy will expect you to report these latest editions on file when you make application for renewal of your permit to conduct a pharmacy for the year commencing July 1st.

PUBLIC RELATIONS FOR SOUTH DAKOTA DRUG STORES

The South Dakota Pharmaceutical Association is again sponsoring public relations broadcasts over radio station KUSD, Vermillion, in their "Fight for Life in the Atomic Age" series. The programs, this year, will be dramatized by the University Speech Department. They will reveal how research has made many new drugs available for the treatment of disease and how pharmacy makes these new drugs available to the public by way of prescription and over-the-counter sale. The programs will point out why pharmacists are not permitted to sell certain drugs except on prescription and why refills must have the approval of physicians in certain cases. They will try to point out that the pharmacist is not trained to diagnose and that close cooperation between physicians and pharmacists is the only way that customers can be assured of the best service in medical treatment. Our programs will originate over KUSD at 4 p.m. on March 9th and March 16th. They may be heard transcribed over other South Dakota stations which carry the "Fight for Life" series." Harold Tisher of Yankton will speak as the narrator to introduce both of our radio programs.

PRESCRIPTION FEES EXCLUDED FROM PRICE REGULATION

The professional fees of pharmacists are exempt from Federal control of prices, along with fees of other professions. It is express in plain words on page 14294 of the Congressional Record of Sept. 1, 1950. The matter was discussed on the floor of Senate and the conferences committee agreed that the professional fees of pharmacists were excluded from Federal control of prices. No one is in an official position to ignore the clear intent of Congress.

We should thank the N.A.R.D. for their work in getting this matter out in the open so we know where we stand.

It perhaps will be ruled that the prices of drugs used as ingredients in compounding the prescription are frozen and accordingly it is advisable to continue charges for ingredients your made during the base period. But if you see fit to adjust your professional fees you are free to do so.

AUXILIARY ACTIVITIES

With all the rush of the holiday season, the material for the January Journal arrived at the South Dakota Medical Association Office too late to be published in that issue, so it will appear in the February Journal. However, our first NEWSLETTER was mailed out on February 1st, and I sincerely hope that all of you found some information on it that made it worth while. I have received some complimentary letters on it so we can feel repaid for the time and work that was involved in getting it assembled and out to each of you.

There will be another NEWSLETTER sent out about the middle of April with news and information about the State Meeting to be held in Aberdeen, June 3-6. Make a note on your calendar on these dates and start planning to be in Aberdeen for this annual meeting. We are planning to have some sort of a School of Instruction for the District Officers this year, which will enable them to carry on their responsibilities for the next year.

NATIONAL SENDS MATERIAL TO DISTRICT PRESIDENTS

Early in February, packets of material were sent out to all District Presidents from the Central Office in Chicago. This project is one of the new services offered by National and is part of the procedure known as the EXTENSION WORK PROGRAM. This is being made possible by an increase in the annual budget, which was accepted at San Francisco last June. This important project will be of great value both to the State and District Auxiliaries in planning their programs and activities. Take advantage of the material in the packets.

Why not make your next Auxiliary meeting an **instructive** one, and dispense with your social program! Read your National President's letter of explanation from the packet and then continue with any one of the enclosed pamphlets. Certainly there can be no more timely subject to discuss than the book-

let "SURVIVAL UNDER ATOMIC ATTACK" distributed by the Council on National Emergency Medical Service of the AMA. Or read the PR Agenda sent out by the National Chairman of Public Relations, Mrs. Heinz. For variety or for another meeting ask some to give a review of the timely book, "SANTA CLAUS, M.D." W. W. Bauer. Dr. Bauer's amusing style makes this book on such a serious subject very interesting. Try a meeting of this kind next time. This material is sent to be **used** not just ignored!

Write your comments, both pro and con, and send them to me. Tell me which pamphlets you used and what method you used, simple discussion, mere reading or both.

AUXILIARY ACTIVITIES DISTRICT NEWS

President visits Huron District

At the suggestion of our state president, Mrs. A. P. Reding of Marion, a special meeting was called on January 13th at the home of Mrs. Joseph Tschetter.

Mrs. Tschetter, president, presided at the business meeting, which included the election of officers. Then Mrs. Reding spoke to us on the changing National Auxiliary policies and how we must revamp our activities to coincide with them. She also gave a report on the Chicago Conference for State Presidents and President-elect, which she and Mrs. Wold attended in November. Mrs. Reding urged the use of the auxiliary pledge at the opening of each meeting and suggested that some form of discussion on some phase of Auxiliary work should be used at our meetings. Samples of some other literature available, copies of Today's Health and other material were displayed. Members were asked to participate in the promotion of the sales of Today's Health.

Our hostess served a lovely lunch at the close of the meeting.

New officers elected are

Pres. _____ Mrs. Fred Leigh
Vice-Pres. _____ Mrs. Paul Tschetter

Sec.-Treas. _____ Mrs. Theodore Hohm

DISTRICT III Elects Officers

An election of officers was held at a recent meeting of District III at Brookings. They are:

Pres. _____ Mrs. Don Scheller, Arlington

Vice-Pres. _____ Mrs. E. E. Watson, Brookings

Sec.-Treas. _____ Mrs. Walter Patt, Brookings

Also the following Committee Chairmen were appointed:

Program _____ Mrs. E. S. Watson, Brookings
Organization Public

Relations _____ Mrs. Don Scheller, Arlington

Legislative _____ Mrs. M. C. Tank, Brookings
Today's

Health _____ Mrs. Walter Patt, Brookings

Bulletin _____ Mrs. F. E. Boyd, Flandreau

FORTIETH ANNUAL MEETING

Plans are being formulated for our fortieth annual meeting which will be held in Aberdeen on June 3-6. This will be in conjunction with the Seventieth Annual Meeting of the S. D. Medical Association. The meeting will be extended an extra day this year to take care of additional group meetings and other important business. This will give the Auxiliary extra time, which we plan to use for further instruction of the members.

National President-elect to be Guest

We do plan to have Mrs. Harold W. Wahlquist of Minneapolis, our National President-elect, as our Convention guest this year. Because the dates of the A.M.A. follow so close after our convention (June 11-16), it is doubtful that Mrs. Wahlquist will be able to stay for the entire meeting, as our other guests have been able to do. However, as soon as Mrs. Wahlquist's plans are definite, we will arrange our sessions to best coincide with her time. Mrs. Wahlquist had to be active in both state and national auxiliary work for a number of years. She is a good, forceful speaker with such a pleasing personality, that I know all who are fortunate enough to hear her, will find her remarks most inspiring.

School of Instruction Planned

A School of Instruction for all District Officers will be incorporated into the sessions this year. This will be of great value to the officers and committee chairmen who will have charge of the district auxiliaries for the coming year. Altho plans are not complete, we

will have some outside speakers from other state auxiliaries, who will be able to tell us how much these schools have helped in their work. This will certainly tend to make our whole state more unified in purpose and objectives. Only a well informed group of officers, chairmen and members working toward an ultimate goal can produce a progressive organization.

All officers and chairmen of standing committees should make a special effort to attend the convention, especially on the day when the School of Instruction is to be held. Any member will be very welcome at these discussion periods.

DISTRICT NEWS

Eighth District Plans Ahead

The spring meeting of the Eighth District was held in Vermillion March 15th. Auxiliary members met with their husbands for dinner at the Congregational Church Dining Room. Following the dinner the doctors held their scientific meeting in the science Hall on the University Campus, while the ladies met in the church parlors.

Mrs. D. B. Williams, district president, presided at the business meeting which included reports of the standing committee chairman and the bi-annual financial report by the Treasurer, Mrs. T. H. Sattler.

The rest of the evening was spent with discussion trying to formulate plans for a regular program of discussions and work projects for the next year. District Eight has been handicapped in the past because there were only two meetings each year. Recently the District Medical Society voted to have regular meetings every other month, thus the auxiliary will meet at the same time and much more activity is anticipated. The following Program committee was appointed: Mrs. A. B. Scales, Pickstown, Chairman; Mrs. C. B. McVay, Yankton; Mrs. Merritt Auld, Yankton and Mrs. A. J. Smith, Yankton. A report will be given at the next meeting in May.

Mrs. A. P. Reding, State President, a member of our district, was able to give us a great deal of information, which will help the plans for a constructive program for next year.

These are the Committee Chairmen:

Organization _____ Mrs. Brooks Ranney, Yankton

Program _____ Mrs. A. B. Scales, Pickstown

Legislation _____ Mrs. E. R. Schwartz, Wakonda

Public Relations & Publicity

Mrs. J. P. Steele, Yankton
 Today's Health.....Mrs. Merritt Auld, Yankton
 Bulletin.....Mrs. Theo. Sattler, Yankton
 District Five Rates 93% in Today's Health
 Sale

Each member in every district was asked to sponsor the sale of A.M.A.'s own health magazine this year. National set a quota of one subscription per member in each district. The Huron District sold 14 out of 15. That should shame the others of you who did nothing.

This district is having regular meetings since the first of the year. They are planning an active program for the future.

Following chairmen will have charge of the various projects:

Organization.....Mrs. John C. Hagin, Miller
 Program.....Mrs. W. H. Saxton, Huron
 Legislation.....Mrs. R. A. Buchanan, Huron
 Public Relations & Publicity

Mrs. Clifford F. Gryte, Huron
 Today's Health.....Mrs. Paul Tschetter, Huron
 Bulletin.....Mrs. Paul Hohm, Huron

ABOUT TODAY'S HEALTH

Any of the districts that have not already taken an active part in the promotion of this fine health magazine, which should be in every doctor's office, as well as every public reading room, may still do their part. All subscriptions can be sent in at any time and South Dakota Auxiliary will still receive credit. Get busy today and complete your quota per district. The subscription rate for doctors, dentists, nurses or auxiliary members is only \$1.50 per year. Send your subscriptions to Mrs. Merritt Auld, State Chairman, Yankton, South Dakota. Do it TODAY!

DUES ARE PAST DUE

As you have all been told before, your annual dues, \$3.25 are due on or before March 1st. Those who have not paid theirs for this year should do so at once. We want to maintain our last year's record of 287 members and better it if we can. Either send your check to your District Treasurer or direct to the State Treasurer, Mrs. V. V. Volin, 205 S. Prairie Ave., Sioux Falls, S. D. Her reports must go to the National Treasurer as soon as possible.

Mrs. A. P. Reding
 State President

ALUMNI CHAPTER ORGANIZED

The Sioux Empire Chapter of the S. D. State College Alumni Association was organized at Sioux Falls on February 14th. Most all of the graduates of the Pharmacy Division living in Sioux Falls are active members. Thomas C. Mills (1947) was elected president of the chapter.

(Continued from Page 81)

ialis which contributes most to the last few degrees of knee extension.

In walking, with or without crutches, the knee should not be held stiffly in extension lest the muscle fatigue and atrophy. Walking with a passive pendulum motion at the knee does not develop muscle strength. As the leg is moved forward the knee should flex slightly in order to relax the quadriceps. As the heel strikes the ground the quadriceps should contract in order to extend the knee fully and give the individual a secure gait. If the surgeon holds his hand on the patient's thigh during a few practice steps, he will readily detect the quality of the muscular action and be able to prescribe corrective measures. Steps should be symmetrical in length and timing. A good motto for the convalescent patient undergoing quadriceps rehabilitation is "Every Step an Exercise."

(Continued from Page 83)

Other bills of interest to the medical profession are explained briefly below:

S. B. 135 Required all coroners to be licensed physicians — defeated in House.

S. B. 311 Rewrote vital statistics laws. Defeated in Senate.

S. B. 312 Set up area health departments — abolished city departments. Defeated in Senate.

H. B. 206 Added nurse and pharmacist to Advisory Council of the State Department of Health replacing lay members. Passed and became law.

H. B. 290 Proposed to abolish Advisory Council to State Department of Health. Defeated.

H. B. 291-292 Put Sanator and State Soldier's Home under one Board.

H. B. 356 — 357 Re licensing of homes for the aged and hospitals. Killed by request of the sponsors.

Malignancies of the Spinal Cord and Peripheral Nerves*

Ernest Sachs, M.D., Research Associate in Physiology and Lecturer in Surgery
Yale University, New Haven, Connecticut

Before considering the diagnosis and treatment of malignant diseases of the spinal cord and peripheral nerves, which I have been asked to present to you, it is well to consider what types of malignant tumors occur in the spinal cord and peripheral nerves.

In the spinal cord and canal, there are three locations that a tumor may occupy in relation to the spinal cord. A tumor may be extradural, intradural but extraspinal, and intramedullary, that is, in the substance of the cord.

The extradural tumors are not tumors developing from or in the nervous system but all the symptoms they give rise to are due to compression of the cord. These tumors are

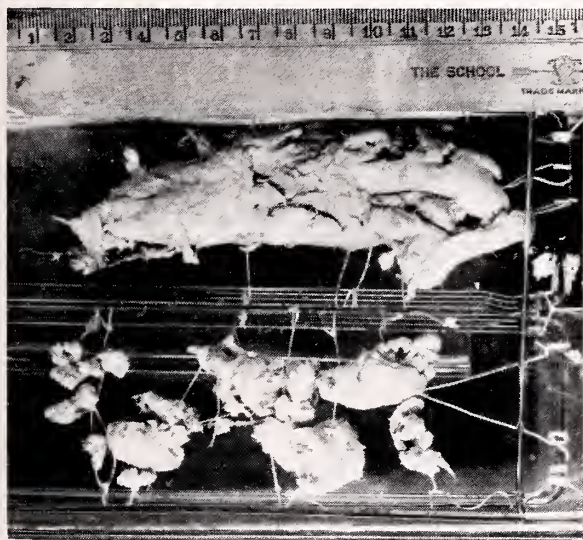


FIGURE 1: Large intramedullary cervical ependymoma.

usually sarcomas though occasionally a metastatic carcinoma to the spine may produce an identical picture. The tumors that are intradural but extramedullary may arise from the nerve sheaths and whereas many of them, in fact most of them, are benign, they may undergo malignant degeneration. These tumors are perineurial fibroblastomas and

grow slowly until they become malignant. In Von Recklinghausen's Disease, this is the type of tumor we encounter. These tumors may be dumbbell in shape, one part in the subdural space and compressing the cord, the other part, and usually the larger portion, grows through the dura and extends into the surrounding tissue in the neck, into the chest or into the retro-peritoneal space, depending at what level the lesion is located.



FIGURE 2: Von Recklinghausen's Disease, showing numerous nodules on the back.

The intramedullary tumors grow from the tissues of the cord; they are some form of glioma. They may be the very malignant type, glioblastomas, or they may be relatively

* Read at the meeting of the South Dakota Field Army of the American Cancer Society, Sioux Falls, South Dakota, October 11-12-13, 1948.

benign, astrocytomas, or they may grow from the central canal of the cord in which case they are ependymomas. These ependymomas may become very large. I removed one nine years ago that weighed 63 grams and had to remove nine spinous processes in order to remove it completely.⁵³



FIGURE 3: Enlargement of the foot in Von Recklinghausen's Disease.

It is difficult to draw the line accurately between benign and malignant tumors. Certainly the rule that ordinarily holds with malignant tumors elsewhere in the body is not applicable to tumors of the nervous system. Tumors of the nervous system rarely metastasize so that criterion cannot be used. However, if infiltration is the determining factor, these tumors I have just mentioned fulfill that requirement.

The diagnosis of a lesion of the cord depends on the symptoms of compression of the cord. At first the patient may have girdle pains corresponding to the upper level of the lesions or there may be loss of sensation unaccompanied by pain. With the loss of sensation there may be weakness of the lower extremities and reflex changes. The type of reflex changes depends on the rapidity with which the symptoms develop. If the symptoms develop slowly, the reflexes below the site of the lesion are increased and the patient is spastic with patellar and ankle clonus. On the other hand, if the symptoms come on suddenly, within a few days, the reflexes may

be abolished. This is a bad prognostic sign for it usually means a malignant tumor. With these evidences of a cord lesion the dynamics of the cerebrospinal fluid will present a characteristic picture. On Queckenstedt test there is a complete block and jugular compression will cause no rise of the cerebrospinal fluid. The cerebrospinal fluid may be xanthochromic and the protein will be elevated. Normal spinal fluid protein may be as high as 70%. In these cases of cord compression the protein percentage may be over 1,000% and in a few cases we have seen it even higher than that so that the fluid coagulated the moment it ran out of the needle.

The exact level of a lesion can be determined by the injection of a contrast medium — Pantopaque. With the other cord symptoms these patients usually have retention of urine.

One would like to know before operation whether the lesion is extra- or intra-dural but this on the basis of symptoms alone is impossible to determine positively. If the symptoms come on rapidly and without pain, the lesion is probably a malignant one and is more likely to be extradural since that is the more usual location of a malignant lesion. The absence of pain points rather to an extradural lesion or an intramedullary one. An intradural, extramedullary lesion is most frequently accompanied by pain due to involvement of the posterior roots. A tumor is more frequently benign when in this location.

We now come to the question of treatment. Every tumor compressing the cord should in my opinion be explored, first to determine its location and, secondly, to determine the pathology. If the tumor is extradural and a sarcoma, it can rarely be benefited even temporarily and never, in my experience, cured. Even if the tumor is thoroughly cleaned out and treated with deep x-ray therapy, there will be no improvement. But if the tumor is intradural the story is very different. These cases are usually meningeal tumors and usually are benign but sometimes undergo malignant degeneration. If the process is not too extensive its removal may give the patient relief and often a long period of improvement. Sooner or later, however, the symptoms and signs are likely to return. A secondary attempted removal is much less satisfactory on account of the associated adhesions.

The third type of tumor is one in the substance of the cord, an intramedullary lesion. Surgical attack on tumors in the substance of the cord is a very serious undertaking for the danger of causing a complete paralysis is very great. But it is possible to remove some of these tumors and get a permanent cure. The ependymomas which grow from the central canal are quite favorable cases. It is amazing how large these tumors may become and yet can be dissected out. It is, of course, impossible to remove a large intramedullary tumor without traumatizing the cord to some extent so that these patients usually will have some disability. The patient on whom I removed the very large ependymoma, about 25 cm. long, is very spastic, as she was before operation, and can only get around in a wheel chair, but she is able to make a living by making children's dresses and does amazingly lovely needle work in spite of the fact that the disability involves her hands. Glioblastomas and astrocytomas also occur in the substance of the cord. For the former nothing can be done but the astrocytomas, if they are cystic, can be cured by removing the nubbin or growing part of the tumor just as we do with astrocytomas of the brain.

None of these tumors respond to x-ray therapy and it is quite useless, therefore, to give them any x-ray treatment. But there is one type of tumor which metastasizes to various parts of the subarachnoid space that responds remarkably to deep therapy. That is the medulloblastoma.⁵² These tumors are usually primary in the brain and the spinal

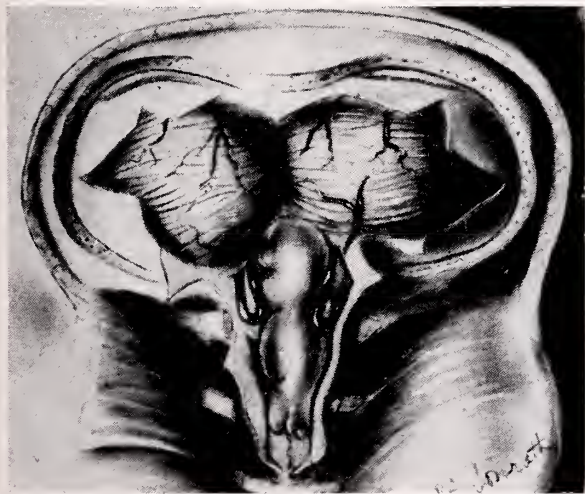


FIGURE 7: Medulloblastoma of the fourth ventricle and cervical cord.

deposits are secondary. I have seen patients with spinal deposits whose symptoms have cleared up completely repeatedly after x-ray therapy. Ultimately, however, they become radio-resistant and finally x-ray is of no avail.

Tumors of the peripheral nerves may be divided into six groups according to the work of Stout and Adair:

1. Neuromas.
2. Tumors involving nerve terminals — glomus tumor.
3. Nerve sheath tumors, neurinomas or perineurial fibroblastomas.
4. Nerve sheath manifestations of von Recklinghausen's Disease.
5. Malignant tumors, fibrosarcomas, neuroepitheliomas, metastatic tumors.
6. Doubtful tumors.

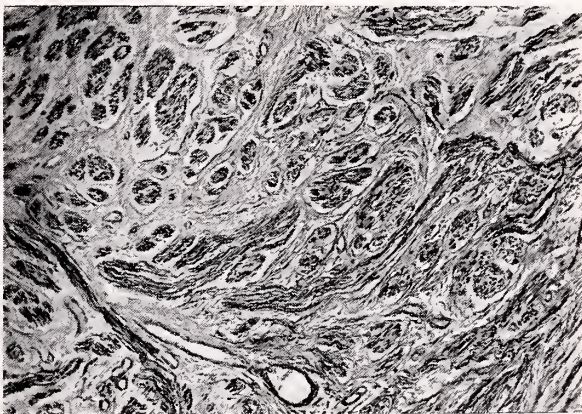


FIGURE 9: Axis cylinders in a neuroma.

Of these different tumors, there are only three that need to be considered because of malignancy. First, that strange tumor occurring under the finger nail known as a glomus tumors.⁵ They are spoken of as neuromyxoarterial glomuses. They are a complex of small blood vessels, the end organ of the nerve and smooth muscle. Just what the relation of these tumors is to other nerve tumors is not definitely known but they have much in common with the neurofibromas seen in von Recklinghausen's Disease. Glomus tumors are rare but are most commonly found growing under the finger nail. The outstanding symptom is pain, very intense and incapacitating. These tumors do not metastasize and can usually be cured by radical excision but they recur locally. Histologically these tumors look somewhat like fibrosarcomas.⁵

A much more common tumor and one that at times undergoes malignant degeneration develops from nerve sheaths and is a manifestation of von Recklinghausen's Disease. These tumors may develop anywhere in the body, in the skin or intracranially.⁵ In these tumors there is a proliferation of the tissue composing the peripheral nerves including both the axis cylinders and their sheaths. When they develop along the peripheral nerves they may assume a variety of forms. They may simply form non-encapsulated nodules in the skin, called cutaneous neurofibromas, or they may form generalized thickened areas which have been called by various names but often are spoken of as elephantiasis neuromatosa. These tumors may become very large and cause marked deformities. They have been thought at times to be lymphangiomas but a careful study has shown them to be of nervous origin.⁵⁴ Some of these tumors undergo malignant degeneration. In the same patient one may find numerous perfectly benign lesions in the skin, the "café au lait" spots so characteristic of von Recklinghausen's Disease. In one patient I observed some years ago there was an eighth nerve tumor, countless pigmented areas on the body and a huge deformity of the foot which necessitated a partial amputation of the foot. When these tumors develop intracranially, usually in the acoustic nerve, they produce the symptoms of a brain tumor. Just why these tumors de-

velop much more commonly in the eighth nerve has never been explained but they do occur along other cranial nerves but usually do not become large enough to produce symptoms. I have only once encountered a very large tumor along the third nerve. The clinical picture these eighth nerve tumors produce is very characteristic. When they are seen they usually present the typical picture of a tumor in the posterior fossa. As a rule, when they come to the neurological surgeon, they have marked intracranial pressure, with choked discs and accompanying headache and vomiting and give evidence of cerebellar involvement, ataxia, incoordination and nystagmus and loss of sensation in the face and facial paralysis, but in going into their history carefully we find that the first symptom, often years before the general cerebellar symptoms appeared, are referable to the eighth nerve. First tinnitus and then gradual loss of hearing. Occasionally, we see patients with eighth nerve tumors who present no general symptoms of a tumor, no choked disc and no cerebellar signs. These tumors grow in the

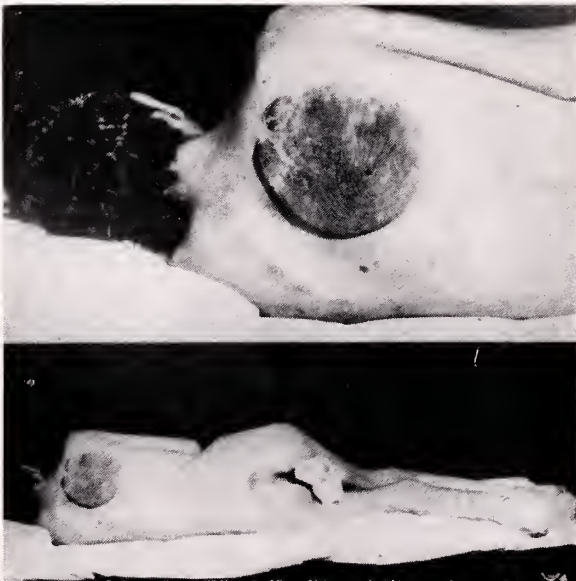


FIGURE 4: Another type of lesion seen in Von Recklinghausen's Disease.





FIGURES 5 and 6: Van Recklinghausen's Disease showing nodules, pigmented areas and a large pedunculated mass which in Figure 5 is thrown over patient's shoulder.

cerebellopontine angle and at times, but not often, undergo malignant degeneration.

The most common malignant tumor of a nerve is a fibro-sarcoma. This is a mesoblastic tumor and contains long spindle shaped cells and grows so rapidly that it frequently undergoes degeneration and necrosis. In the 140 cases that Sout collected from their large material at Memorial Hospital and the literature, over 100 occurred in patients with von Recklinghausen's Disease. These tumors his-

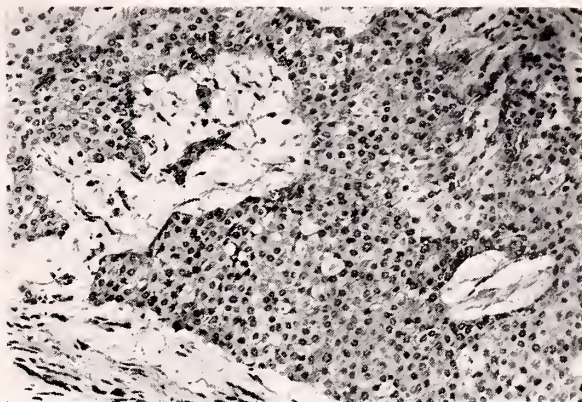


FIGURE 8: Oligodendroglioma showing the large glial cell bodies around the pigmented nuclei.

tologically look no different than other sarcomas but they rarely metastasize; however, local excision even though extensive is practically always followed by a recurrence; therefore, if located in an extremity, amputation offers the best treatment. These tumors do not respond at all to radio-therapy so that no time should be wasted trying that method of treatment. If the tumor is located elsewhere than in an extremity, the only hope is by extensive excision.

Fortunately, peripheral nerve tumors that undergo malignant degeneration constitute a rather small group for the prognosis in these cases is very poor.⁵

**I am available
for relief work as
registered
pharmacist**

F. C. Fergen
734 E. Center
Madison, S. D.

Choice of Kidney Incision

Robert F. Livingston, M.D., Yankton Clinic, Yankton, South Dakota
William L. Valk, M.D., Univ. of Kansas Medical Center, Kansas City, Kansas

Adequate and safe exposure have long been recognized as the criteria of a kidney incision. Although nephrectomy may be an easy operation, the difficulty at times of adequate safe exposure is evident from the many incisions recommended by many capable surgeons. The divergence in methods lies in the fact that no one incision will meet all of the pathological conditions of the kidney.

HISTORY

Most of the incisions recommended have been extraperitoneal. The transperitoneal approach, though recommended for large tumors and exploration of the opposite side,

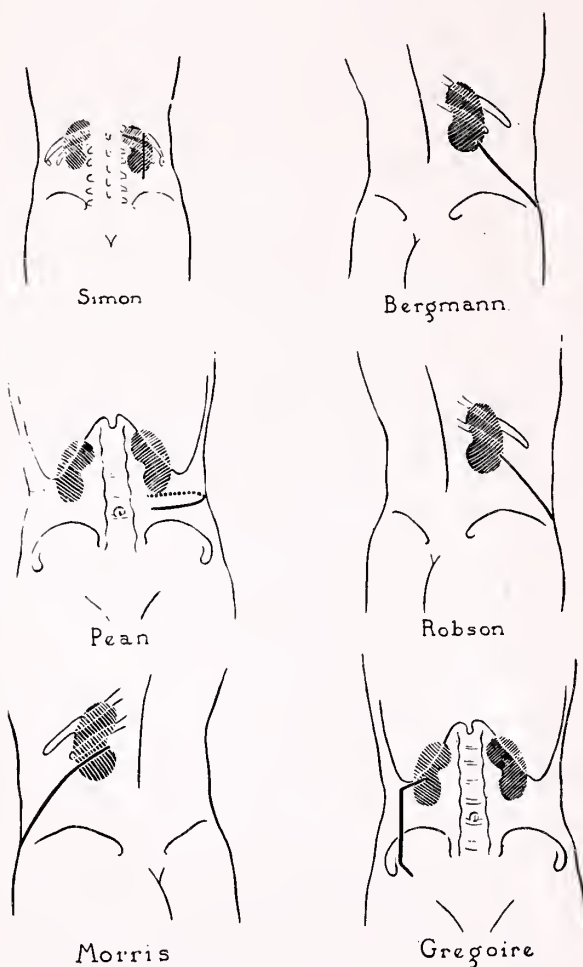


FIG. 1. Representative Kidney Incisions

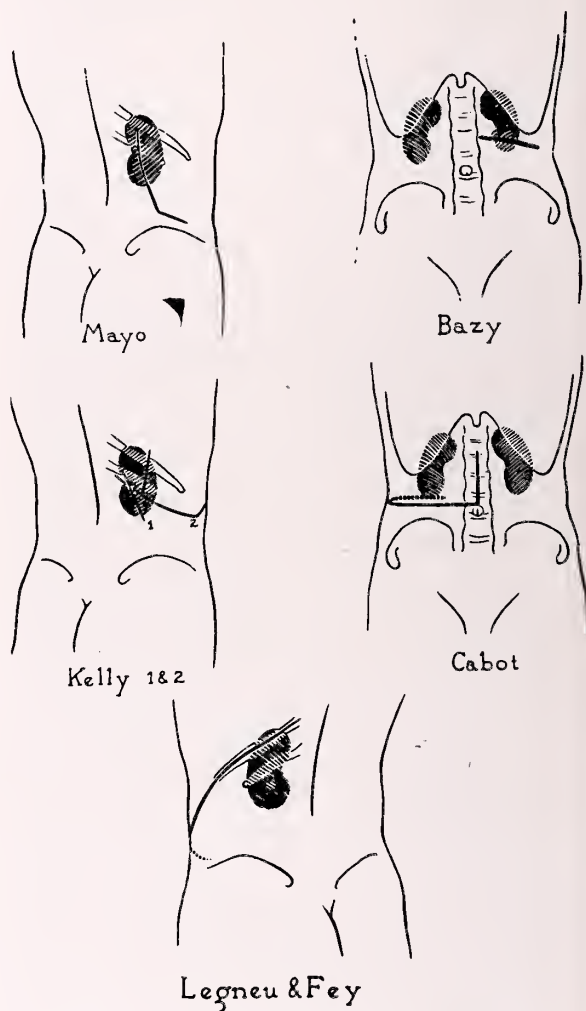


FIG. 2. Representative Kidney Incisions

is now used by few surgeons because of the predisposition to shock and bowel complications.

A review of the kidney incisions recommended shows wide divergency in attempts to solve this problem. Extraperitoneal incisions may be divided into four groups: posterior vertical incisions, oblique lumbar incisions, transverse incisions, and trans-thoracic incisions. Fig. 1 and 2 — Representative Kidney Incisions.

The first planned nephrectomy which was performed by Simon in 1869, utilized an extraperitoneal vertical incision.²⁸ This in-

cision was nine to ten centimeters in length along the outer border of the sacrospinalis, beginning over the eleventh rib, crossing the twelfth, and extending down in a perpendicular direction to the middle of the space between the twelfth rib and the crest of the ilium.

Modified vertical incisions were described by Czerny¹⁰, Hahn¹⁴, Kuster¹⁹, Von Bergmann³⁰, Poncet²⁵, Duret¹², and Konig¹⁸.

D'Antona¹¹ describes an oblique incision which he states he used for the first nephrectomy for tuberculosis in 1882. The incision commenced at the eleventh rib, four or five centimeters of which were resected, and was prolonged in a curved line to the crest of the ilium passing in front of the twelfth rib.

It is interesting that Czerny¹⁰, Kuster¹⁹, and Von Bergmann³¹ abandoned their early vertical incisions for oblique ones to acquire greater exposure. The "classical oblique incision" is attributed to Israel¹⁶. This incision commenced at the costolumbar angle and was directed towards the anterior superior spine, passing two centimeters above it, then descending parallel to the crural arch. Oblique incisions have been recommended also by Albarran², Morris²², Chevassu⁷, Rosenstein²⁷, Mayo²¹, and Kelly¹⁷. Abbe¹ and Robson²⁶ describe muscle splitting oblique incisions. The Mayo²¹ incision is widely used. This consists of a lumbar incision beginning at a point two and one half inches lateral to the dorsal spines near the outer margin of the sacrospinalis muscle extending longitudinally for two or three inches to a point one half an inch below the level of the angle of the twelfth rib. From this point, the incision passes obliquely downward and forward along the anterior margin of the quadratus lumborum muscle to a point an inch above the crest of the ilium, there turning and running forward parallel to the iliac crest as far as necessary.

Kelly¹⁷, for conservative kidney operations, described an incision beginning somewhat above the middle of the twelfth rib extending downward and slightly forward to a point midway between the spinous processes of the lumbar vertebrae and the anterior superior spine of the ilium. The latissimus dorsi and oblique muscles were split exposing Petit's triangle. For extensive exposure, Kelly recommended enlarging the

superior lumbar triangle in one of four ways: extending the incision downward obliquely parallel to the iliac crest, making a gridiron incision similar to that of Abbe and Robson, resecting the twelfth or eleventh ribs, and an additional medial vertical incision. He also recommended a transverse incision with a perpendicular branch with resection of the eleventh and twelfth ribs.

Pean²⁴, in 1894, made a transverse incision extending from the outer border of the sacrolumbar mass at the level of the umbilicus around to the lateral border of the rectus abdominus muscle.

Bazy⁵ described an anterior transverse extraperitoneal incision limited to the anterior aspect of the abdomen beginning below the palpable eleventh rib and extending transversely toward the midline midway between the umbilicus and xyphoid process. The patient was placed on the back in hyperextension.

Cabot⁶ described a transverse incision commencing at the anterior border of the sacrospinalis and extending not far from the border of the twelfth rib to the midline at the level of the umbilicus. From this incision, he made a branched upward midline incision allowing raising of a triangular flap. The peritoneum was lifted from the posterior wall.

Legneu and Fey²⁰, in 1925, described a thoracoabdominal incision consisting of a thoracic and abdominal incision which converged at the tip of the eleventh rib. The external oblique was incised in the direction of the fibers from the crest of the ilium to the tip of the eleventh rib and carried ten to twelve centimeters along the rib.

Costantini and Bernasconi⁹, in 1930, for nephrectomy in cases of Pott's disease with large lumbodorsal gibbous described a thoracoabdominal incision over the tenth rib.

Chute and Souter⁸, in 1949, recommended for left nephrectomy incision from the lateral border of the rectus muscle at the level of the umbilicus running laterally and upwards posteriorly over the eleventh rib to the spine, a combined abdominal and transthoracic approach.

O'Connor²³ describes a transthoracic approach for right nephrectomy.

DISCUSSION OF RECOMMENDED INCISIONS

The early extraperitoneal posterior vertical

incisions were abandoned in most cases by their authors in favor of other incisions giving more exposure.

The hazards of the transperitoneal approach, infection, bowel injury, and greater predisposition to shock, are well understood, and most surgeons have abandoned this approach.

The multiplicity of oblique lumbar incisions attest to the difficulty of adequate exposure by this route. Many of these incisions completely disregard nerve injury. Although postoperative hernia is not as common in lumbar incisions as in vertical anterior abdominal incisions, paresthesias, anesthetics, and even pain may be distressing for years following nerve injury.

Transverse incisions have been recommended by Kuster, Pean, Tillmann, and Bazy. Combinations of transverse incisions with other incisions have been proposed by Von Bergmann, Poncet, Bardenheuer, König, Kelly, and Cabot. Each of these authors utilized the transverse incision to obtain greater exposure. The transverse incision of Pean endangers the peritoneum when extended medially and is too low, at the level of the umbilicus. The transverse incision of Bazy limited to the anterior aspect of the abdomen gives satisfactory anterior exposure of the hilum, but not posterior exposure.

The transthoracic route, although giving adequate exposure, would seem to add the hazards of pulmonary complications and increased operative time.

METHOD OF TRANSVERSE SUBCOSTAL INCISION

With the patient under endotracheal ether anesthesia and placed in the arched lateral position, the surgeon stands at the patient's back. The incision is made one to two finger breadths below the costal margin beginning at the lateral edge of the rectus abdominus muscle and extending transversely or slightly obliquely to the latissimus dorsi muscle. (Fig. 3, Transverse Subcostal Incision). The incision is carried through the obliquus externus, internus, and transversus muscles and their fascia, being deepened laterally first where the lumbodorsal fascia is a good landmark. The peritoneum is retracted medially under vision while the transversalis fascia is opened and the incision completed. The twelfth nerve is the only one liable to injury in this incision

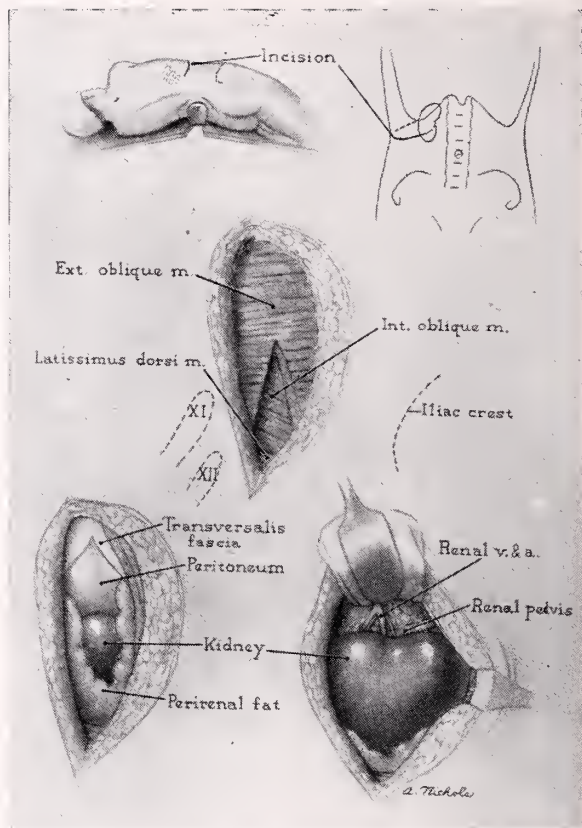


FIGURE 3: Transverse Subcostal Kidney Incision. and it may be avoided frequently.³

It is not the purpose of this paper to discuss all of the techniques of kidney surgery, but suffice it to say that all of them are greatly facilitated by direct vision and adequate exposure. The transverse subcostal approach affords anterior as well as posterolateral exposure and excellently exposes the hilum and upper pole. This permits ligation of the pedicle prior to mobilization of renal tumors. Adequate room to remove the largest masses is afforded, the bridge between the costal margin and iliac crest having been divided. All of the advantages of extraperitoneal approach are easily obtained. There is minimal nerve injury in cases where complete ureterectomy is indicated, a separate lower quadrant incision enables complete removal of the distal ureter.

SUMMARY

The history of kidney incisions is reviewed. A transverse subcostal extraperitoneal kidney incision is described. This method has been successfully used for nephrectomy. It would seem advantageous in all kidney procedures where adequate exposure is essential.

(Continued on Page 130)

Rehabilitation of the Handicapped

Dr. T. F. Riggs, Pierre, South Dakota

Consultant for State Division of Vocational Rehabilitation

The problem of the handicapped is one that concerns all citizens, it is a job for all of us.

The disabled persons whom we rehabilitate are the people who now live in our state. They will prove either burdens or assets to their communities. They will either reduce or increase the wealth of our state and it is largely up to us to decide what their status will be.

Every physician should take a lively interest in any legitimate effort which is being made to improve the physical and mental condition of that portion of our population who are financially or otherwise unable to secure proper medical, educational, or employment assistance necessary to become vocationally rehabilitated. One such effort is the work of the State Division of Vocational Rehabilitation. This federally aided state program has as its sole objective the preparation of permanently disabled men and women for suitable types of self-supporting employment.

No charity — this rehabilitation program. It is strictly a matter of helping the disabled to acquire a skill that will enable them to become self-supporting citizens. The loss of an arm or a leg, a crippling accident, or disease such as polio, or a long battle with tuberculosis may get even the best of persons down. The future can look mighty dismal when an artificial leg or a needed operation stands between the disabled and the possibility of becoming self-supporting and living a normal life. That's when the handicapped person needs a helping hand and that's the work of the program of Vocational Rehabilitation. It is simply a public service available to the disabled when they need it.

Persons who are residents of South Dakota and who are 16 years of age or older and who have a physical or mental disability, regardless of source, which is a vocational handicap, should be referred to the Division of Vocational Rehabilitation, Pierre, South Dakota. Rehabilitation counselors will be glad to assist in planning the most feasible program

for the disabled individual.

The physician contributes one of the essential functions in the service of Vocational Rehabilitation.

Medical and psychiatric examinations are secured as a part of the basis for the determination of eligibility for rehabilitation services. These examinations are given by qualified physicians of the clients choice. When the medical care recommended is of a highly special nature patients are referred to a specialist who can provide such service.

A disabled person is entitled to whatever medical services are necessary to restore his maximum functions as an active, competitive employee. If a person is not realistically prepared, in as far as possible, to meet his life demands, he cannot be said to have been rehabilitated. Medical information relative to the applicant is a valuable guide to Rehabilitation counselors in the choice of a suitable training course and selective job placement. Any practicing physician qualified by training and experience is eligible to render this service to the Division.

The doctor's findings determine whether the disability can be corrected or materially reduced in a reasonable length of time. It is then the duty of the Physical Restoration Unit of the Division to remedy the condition. Physical restoration may well be referred to as medical rehabilitation. Physical restoration includes medical services and hospitalization, surgery, psychiatry, prosthesis, as well as such auxiliary services as occupational therapy, nursing and convalescent care, work tolerance, training in self-care, ambulation, travel ability and communication. The acquisition of the best possible means to meet the physical demands of personal care, daily living, and employment through functional re-education are obligations of physical restoration. The test is the degree of restored effectiveness. It is not enough to provide surgery alone and hope for the additional skills to be acquired. In every case where necessary,

the auxiliary services should be provided. Thus, it is seen that physical restoration is a basic and integral part of the process of rehabilitation but it is only the foundation and not the complete structure.

The general requirements for eligibility for medical services are that the disability is, or contributes to, the employment handicap; that the disability is static or slowly progressive in nature; that the patient may reasonably be expected to benefit in a substantial way from medical services, and in a reasonable length of time; that the patient will be otherwise employable; and that the patient has financial need for assistance. The services do not include medical care for acute conditions.

Only accredited agencies and qualified physicians are used. All medical care is paid for by a schedule of fees which, while not on the level of private practice, is nevertheless adequate for a public service rendered to indigents. Hospital care is purchased on a basis of actual cost. The widespread cooperation of physicians and hospitals is evidence of the value of the service.

Medical advice in this program is given by the Medical Consultant who acts as a liaison officer between the medical profession and the Division of Vocational Rehabilitation.

Every physician is confronted by the problem of severely disabled, indigent patients who can be restored to productiveness and independence with the aid of a cooperative service such as Vocational Rehabilitation.

The Vocational Rehabilitation record is good but unmet needs are great. First, we need enough trained personnel, money and facilities to provide the services necessary to restore ALL our disabled citizens to useful self-supporting work.

We need a State (or regional) Rehabilitation Center, where the needed therapies and training can be given to the more severely disabled in continuous process without waste of time, travel and money.

We need sheltered workshops, where work tolerance can be developed, training can be provided, and the necessary steps can be taken to prepare many for competitive employment.

We need a program to employ the latent skills of those who must remain home-bound.

We need greater research into the problems

of the blind and their rehabilitation, much stronger study and effort among those disabled by chronic disease, such as epilepsy, multiple sclerosis, osteomyelitis, tuberculosis, arthritis, and the many others that disable a person as completely as an amputation or crippling accident.

We now have more people above 60 than in adolescence. These aging people particularly are subject to disabling ailments, and we need to develop more work opportunities for them, so that their rehabilitation may be complete. Unless we do, the burden of dependency in this rapidly growing group will become too heavy to bear.

The mentally ill and the emotionally disturbed are as disabled as the paralytic. It is being demonstrated daily that many such illnesses can be cured. We need a stronger program of rehabilitation for this group, whose numbers are growing at an alarming rate. In addition we need public understanding of their problems and capacities.

These are a few of the urgent needs — there are many others only slightly less acute.

No little handful of professional rehabilitation workers can do the entire job of rehabilitating our disabled people who must have some such services in order to support themselves — and who can not obtain them by their own efforts.

If this program is to attain its potential worth to the State, the general public must understand that most of the disabled can be rehabilitated into useful self-supporting citizens; must cooperate with all who strive to solve the problems of disability; must support the program in every way possible. Without that, little progress can be made.

The doctors, must realize that in rehabilitation there is hope for almost every disabled patient, if prompt service can be provided. The educators must understand and recognize disability early and take preventive action. Labor must spread understanding and tolerance — to help reduce the resistance to employment of the disabled. Employers must examine their operations and consider the rehabilitated man or woman as a safe, capable, dependable employee. Such associations as the tuberculosis society, the crippled children's groups, the polio groups, and the

(Continued on Page 130)

The Care of Poliomyelitis During the Convalescent Period

W. H. Northway, M.D.

Stanford University School of Medicine

The type and extent of treatment during the convalescent period of poliomyelitis will vary as the definition of "convalescent period" varies in the minds of those carrying out the treatment program, and the variation is of no great importance as long as the term is defined at the beginning of any such discussion of the subject.

This discussion will consider the "convalescent period" as beginning 48 hours after the temperature has become normal and as continuing until no further improvement in muscle strength or in functional activity is taking place. This definition is more extensive than most, and very definitely and purposely includes the teaching of functional activities for daily living as part of the convalescent period. The reason for this becomes obvious when one considers that all of the procedures used during this stage, with the exception of reconstructive surgery, fall in the domain of physical medicine, which includes physical therapy, occupational therapy and physical and occupational rehabilitation. The "convalescent period" from the above definition may therefore last from a few weeks to several years, depending upon the extent of involvement.

There is no specific therapy for poliomyelitis therefore, any treatment program must be based on the treatment of the signs and symptoms of the disease, and the outstanding signs and symptoms may be listed as follows:

1. Pain on muscle action
 - a. Active
 - b. Passive
2. Tenderness, produced by palpation of a muscle.
3. Muscle shortening, or an inability to carry a joint through the full range of motion.
4. Muscle weakness.
5. Muscle paralysis.

It is quite obvious that treatment directed toward the above signs and symptoms is not

going to alter the course of the pathological changes produced in the nervous system by the virus (and no thoughtful person concerned with the treatment of poliomyelitis at the present time would venture such a thought). Also it is well recognized that many patients recover spontaneously with or without treatment and that the degree of permanent paralysis will depend upon the extent of the destruction of the anterior horn cells in the pons, medulla and spinal cord during the acute febrile illness. In spite of the above facts, a treatment program is worthwhile, and the aims of such a program have been ably stated by Gurewitch¹ and his co-workers as follows:

1. Alleviate muscle pain, muscle shortening and limited flexibility.
2. Develop optimal function of the weakened muscles.
3. Rehabilitate patient and make as useful and independent as possible in the face of the handicap.

The majority of workers in the field would agree with these aims of treatment.

A logical, understandable yet simple treatment program is easily formulated if one keep in mind the signs and symptoms to be treated and the aims of the treatment program.

Before a treatment program can be intelligently prescribed, a careful and thorough physical examination must be performed in order to locate the areas of pain, tenderness and muscle shortening. This examination must be carried out as soon as the diagnosis of poliomyelitis is made, and actually the presence of the above signs and symptoms help make the diagnosis. No attempt should be made at the original examination to evaluate accurately muscle strength, but the location of muscle weakness and paralysis should be determined and recorded. Re-examination of the patient is necessary from time to time to note changes in the physical findings just as is done in any other acute disease process and the treatment program altered to meet

the situation.

As soon as the acute pain and tenderness have disappeared, a careful muscle analysis should be performed to determine the location and extent of any paralysis and muscle weakness. All muscle weakness should be carefully graded. An excellent source of information on how to carry out such an examination is contained in the work of Worthingham, Daniels and Williams.² An early evaluation of muscle weakness and paralysis is necessary not only in order to prescribe treatment but also to observe the effects of treatment and to try and evaluate the effectiveness of the treatment program.

Pohl³ in a study of 1,125 cases in 1946 observed no weakness or paralysis in 34.6% at any stage, while 65.4% showed weakness and paralysis at the height of the disease.

All cases showing weakness and paralysis should be treated in spite of the fact that a certain percentage of these cases will recover spontaneously without treatment or with any form of treatment. It is difficult to predict the number of cases that will recover completely.

Sherman⁴ reported 13.7% complete recovery in a group of 51 cases that at some stage of the disease showed weakness or paralysis. In this same group 60.7% showed insignificant weakness, 11.7% definite functional weakness, 13.7% marked function weakness after treatment. In other words, of the 51 cases treated, 75% recovered to a satisfactory degree and 25% did not. In this series of 70 cases, 8.5% died and 18.5% showed no weakness or paralysis at any time.

It has been found by clinical experience that the following physical procedures are useful therapeutic agents:

Rest

Heat

Exercise

Functional activities

Rest is an effective therapeutic agent for the relief of the pain and tenderness associated with muscle activity. The keystone of this procedure is the proper preparation of the bed. A bed board, made of five-ply wood and hinged so that the head of the bed may be raised, is placed on the springs. A firm mattress at least 4 inches shorter than the length of the bed covers the bed board. A foot board is placed at the foot of the bed, resting on the

bed board and extending eighteen inches under the mattress and eighteen inches above the surface of the mattress. A space of four inches between the foot of the bed board and the mattress remains vacant. The footboard serves as a support to keep the weight of the bedclothes off the feet and also serves as a splint to help maintain dorsiflexion of the ankle. The space between the mattress and the footboard serves as a slot for the feet when the patient is face lying and takes the weight off the heels when the patient is in the supine position.

The patient may assume faulty positions during the acute stage of the illness in order to get relief from pain present in the muscles, and these positions may have to be tolerated temporarily until the pain is relieved.

The ideal rest position is either supine or prone lying with a frequent change of position. In the supine position the head may be supported by a small pillow, the arms are parallel to the trunk. The hips are slightly abducted and generally slightly externally rotated. The degree of external rotation may be regulated with folded towels or by small sand bags. The knees are slightly flexed and supported by folded towels, and the feet are kept dorsiflexed by placing them at frequent intervals against the foot board. The ideal position described above is alternated with the prone position, and both of these positions are altered by the early use of passive motion to all joints.

Heat is another effective procedure for the relief of muscle pain and tenderness. Heat may be secured from many different sources, but hot moist compresses have been found to be particularly effective. The procedure is simple to use, is readily available and can be taught to unskilled lay personnel in a short period of time. The only drawback to this method of supplying heat is the labor involved.

Heat in the form of hot moist packs may be applied frequently throughout the day and should be continued as long as muscle pain and tenderness persist. It is discontinued as soon as these symptoms disappear, as at that time it has served its function and to continue is a waste of labor better used for other things.

The rest and heat must be supplemented by another and probably key procedure if

muscle shortening is to be prevented, and this is gentle passive exercise. Gentle passive exercise should be instituted as soon as possible and certainly by the time the temperature has returned to normal if muscle shortening with its accompanying limitation of joint motion is to be prevented. Passive motion through the range of motion that can be obtained without pain is carried out several times a day. If the procedure is carried out properly there should be a progressive increase in range of motion. Passive motion is continued until a normal range is obtained in all joints, including the back and neck. A systematic program for carrying out the passive exercise should be instituted so that all joints receive attention. If joints are kept immobilized by too long a period of rest, the passive motion will have to be reinforced by stretching if a full range of motion is to be obtained. It may take several weeks or months before full mobility is restored to all joints, once shortening has occurred.

Too much stress cannot be placed on the importance of the early and continued use of gentle passive motion and if necessary stretching. Early use of passive motion prevents and relieves muscle shortening with or without the use of heat. The proper use of this most important procedure requires a thorough knowledge of the anatomy of the bones, joints and muscles, with the knowledge of the normal range of motion of all joints. Well trained physical therapists have this knowledge.

In any discussion of the use of passive stretching to relieve muscle shortening, a word should be said about the use of drugs as an aid to this procedure. Prostigmine and curare are the drugs most frequently used, and the latter seems to be the more effective. There is, however, considerable controversy as to the effectiveness of curare. Richards⁵ and his co-workers at the Mayo Clinic in 1947 came to the conclusion that the drug did not affect the clinical course of the disease and did not shorten convalescence. They did not observe any harmful effects, but they recommended that resources be available to deal with untoward effects, should such occur.

Paul and Couch⁶ in 1949 concluded that curare and stretching relieved pain and stiffness much more rapidly than stretching alone.

There appears to be some value in the use

of curare in those cases which are resistant to stretching. The drug should be used only by those who have become thoroughly familiar with its peculiarities, and there is probably little reason to use it in the ordinary case that is responding well to stretching alone.

Exercise is the only procedure effective in increasing muscle power in muscle weakened by the destruction of anterior horn cells, which thereby deprives the muscle of its normal number of motor units. The effectiveness of the exercise program is determined first, by the number of motor units remaining after the acute process has run its course, and second, by the care with which the exercise program is carried out. An increase in power in the muscle can be accomplished by a hypertrophy of the muscle cells which remain activated by undamaged anterior horn cells. This hypertrophy is produced by exercise to the muscle with a gradually increasing load, but the load must not be increased until the muscle is first found to be functioning properly through its full range of motion, and this may not be possible at first unless said is given the muscle by removing the weight of the limb. This is known as active assistive exercise, and can be carried out by the aid of the therapist, by mechanical means, or by floating the patient in water. As soon as activity can be properly performed with the weight of the limb, the position is changed so that it has to be performed against the weight of the limb and gravity, and when this is accomplished then artificial weights are added to the procedure. The therapist must be alert at all times to detect flaws in the normal pattern of activity, as it is most essential that the weak muscle receive the exercise rather than muscles already strong, or abnormal patterns of activity will persist. The patient should not attempt or be asked to perform motions or acts that cannot be carried out properly until it has been determined that no further improvement is going to occur through exercise. Then the final stage in the rehabilitation program will be introduced — that of functional activity.

Paralyzed muscle is treated by maintaining its normal resting length by passive motion. The patient is asked to concentrate on an attempt to carry out the activity while the part is being carried through the motion. The

therapist constantly watches for evidence of a return of function, and this occasionally occurs, generally within the first six months.

Sitting is allowed as soon as muscle pain, tenderness and shortening have disappeared, when good posture can be maintained, and for the period over which the proper posture is maintained.

Standing is allowed as soon as pain, tenderness and muscle spasm have disappeared and when a good posture can be maintained, and for the period over which it is maintained.

Walking begins as soon as muscle power will allow a good pattern of gait. In order to accomplish this in a reasonable period of time, mechanical supports and crutches should be used and continued until the gait pattern is satisfactory without them.

All of the above activities should be introduced cautiously in all patients who have not reached their full growth, and these patients must be carefully watched to detect the appearance of abnormal structural changes as a result of weight bearing, especially scoliosis. If structural changes occur, it may be necessary to increase the period of rest, introduce mechanical supports or carry out surgical reconstructive procedures.

The question as to how long to carry out an exercise program to increase muscle strength is difficult to answer, and there appears to be no agreement among workers in the field.

Hipp⁷ in 1941 concluded that muscles with a grade of zero, trace and poor three months after the acute illness showed no further appreciable gain, but that muscles with poor plus, fair and good showed considerable further improvement.

Gurewitsch¹ came to the same conclusion on observations from 552 patients.

De Lorme⁸, working with a single muscle group, the quadriceps femoris, was able to increase the muscle power in 17 of 27 muscles within four months. Ten of the 17 improved within the grade, and 7 of the 17 increased strength to the next highest grade. These figures compare favorably with those of Gurewitsch. De Lorme has observed improvement in one patient over a period of 15 months in strength and work capacity.

It is safe to state without fear of serious contradiction that all patients should be treated with exercise as long as any increase in muscle strength occurs, and this may con-

tinue over a period of months. This does not mean that these patients must be treated in a physical therapy department all this time, as frequently the exercise program may be carried out at home or in school. In fact, for these patients to maintain their maximum muscle strength, the exercise program should be continued indefinitely.

A patient with severe muscle weakness and paralysis — and this may mean up to 15% of all patients seen — should not be dismissed from medical care until he or she has been taught activities for daily living.

Bennett⁹ has divided these activities into eight groups as follows:

1. Activities of the bed bound patient.
2. Activities concerned with eating.
3. Activities concerned with hygiene.
4. Activities concerned with dressing.
5. Activities concerned with application and removal of necessary apparatus.
6. Activities concerned with the use of various utilities.
7. Activities concerned with communication.
8. Activities concerned with locomotion.

Few if any patients with poliomyelitis need to be bed bound, and all bed bound patients should be carefully evaluated to be sure that such a state of affairs should continue to exist.

Eating activities may be enhanced by the use of specially designed utensils and by the use of overhead slings attached to the bed or chair.

Activities concerned with hygiene are made possible and easier by adjusting the height of the toilet seat, wash bowl and the bath tub, and by the proper placing of these. Doors may have to be widened to enable the easy passage of a walker or wheel chair.

Special design of basic articles of clothing may be necessary to make dressing easy or at all possible.

Apparatus to support the trunk and limbs has to be designed to meet the individual needs of the patient.

Utilities such as water faucets, light switches and heating apparatus may have to be designed to fit the individual need.

Special holders for pencils, pens, typewriters and telephones are easily provided to make communication easier and possible.

(Continued on Page 128)

Pathology of New Growth of the Thyroid Gland

by Ferdinand C. Helwig, M.D.

Department of Pathology, St. Luke's Hospital
Kansas City, Missouri

From a clinical viewpoint it might be said that pathologists have unduly complicated the nomenclature of neoplastic disease of the thyroid gland by enumerating too many different types of growths. Furthermore, it is quite true that such type specialization is ordinarily of only minor clinical significance. What is often revealed with the microscope as a morphologic malignancy may be clinically benign. This doubtless accounts for the great discrepancy in the figures from different clinics regarding the incidence and curability of cancer of the thyroid. Nonetheless, by continued study of morphologic alterations we may gain a more thorough knowledge of the life history of these growths and the pathologists' complicated classifications, therefore, might lead eventually to some clarification of the confusion which now exists.

The most common true tumor of the thyroid, in my experience, is the fetal adenoma. These are slow growing, embryonal growths and may be first discovered in either the goiterous or the non-goiterous gland. They are not too rarely observed in childhood as a little round nodule which may grow for many decades before malignancy supervenes. When buried in a nodular gland they may be discovered only at the time the gland is examined in the laboratory; and then, too often, they have been confused as being mere variants of the hyperplastic nodules rather than independent neoplasms existing for a long time prior to the time when the gland became hyperplastic. They are well capsulated and separated completely from the otherwise normal or goiterous thyroid and may reach a very large size as solitary growths. They can be differentiated from the so-called adenomatous goiter since the latter have only pseudocapsules composed of compressed atrophic thyroid parenchyma. Sometimes when such non-neoplastic nodulations undergo degeneration and liquefaction, they many resemble grossly some of the secondary

changes occurring in fetal adenomas. However, by histologic study they can usually be differentiated with ease. In the early stages of development of such fetal adenomas, they are seen to be made up of either solid cords or columns of cells with relatively slight or no definite formation of follicles and with this structure have been captioned "embryonal trabecular adenomas" (fig. 1). This tend-

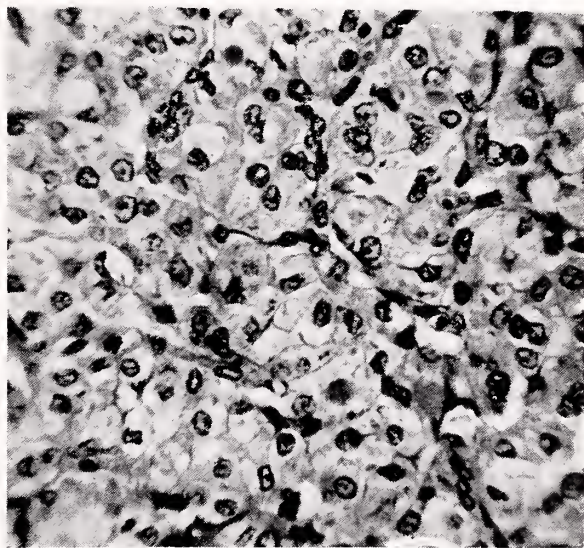


Fig. 1 Trabecular type of thyroid fetal adenoma showing rows of large pale cells sometimes lying on thin vascular channels. (High power)

ency toward column formation is what has given them this name. The younger tumors usually are of a brown or grayish brown color on section, soft in consistency and show varying amounts of fibrous trabeculations which subsequently increase in size as growth continues. When degeneration takes place, the presence of hyaloid, edematous zones of connective tissue taking a pale, acidophilic stain and containing poorly staining cells scattered about are often seen. Secondary areas of hemorrhage and cystic degeneration also are observed frequently and here, likewise, single or multiple islands of solid cells may be found imbedded in this peculiar con-

nective tissue stroma.

The other type of fetal adenoma is that in which very small follicles are found with little or no colloid and there is a tendency for the structures to resemble the thyroid gland of the fetus (fig. 2). The same degenerative

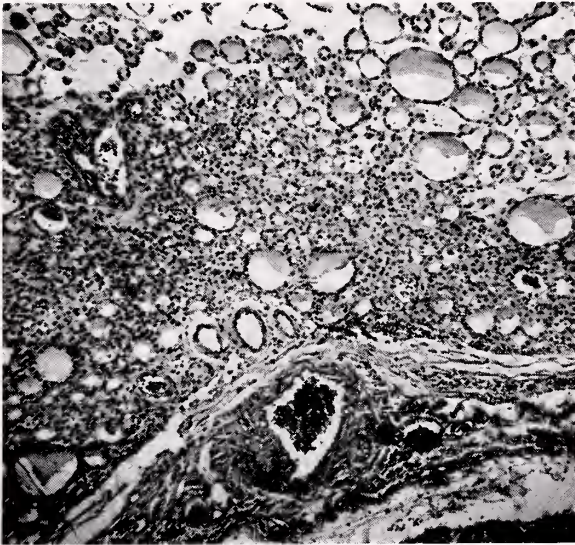


Fig. 2 Small acinar type of thyroid fetal adenoma; some of the larger follicles contain colloid. (low power)

changes take place here as in the trabecular type. In the large, older specimens or even in the smaller non-degenerated specimens, changes in cell type are observed with hyperchromatism, nuclear hypertrophy and deformity, and other cytologic alterations suggesting cytologic malignancy (fig. 3). If the tumor



Fig. 3 Thyroid fetal adenoma showing nuclear variants and hyperchromatism. (Low power)

is still well encapsulated, regardless of such morphologic variants, it can ordinarily be regarded as clinically benign. When, however, the veins are invaded or the capsule completely penetrated, we are obliged to make a diagnosis of cancer although the condition is not clinically malignant^{1, 2, 3}. It should not be overlooked, however, that even when such invasion has not taken place, such tumors on rare occasions may already have become distantly disseminated. It is obviously not feasible to make serial sections of all such tumors; hence, microscopic foci of such extension into venous channels might be overlooked. Furthermore, such invasion may take place in nodules which morphologically do not show any suggestion of cytologic malignancy, at least with the ordinary number of sections taken from such a tumor. In my own experience, as well as in that of many writers, the fetal adenomas have formed the basis for the great majority of carcinomas of the thyroid. Most statistics show that about 80 percent of thyroid malignancies arise in these tumors. As Crile, Hazard and Dinsmore⁴ have recently shown, the metastases from these growths are in most instances by way of the blood stream and they have captioned them "hemangio-invasive carcinomas." Clinically, the transformation of these benign tumors into malignant ones is usually heralded by rapid growth and increased induration. Hemorrhage into such tumors is not at all uncommon but the tumor remains elastic on palpation, does not have the "hard feel" of cancer, and the increase in size is much more rapid than when malignant transformation takes place. Moreover, when the gland is removed, the density of malignancy and changes in gross character can usually be detected by palpation and naked eye examination.

The third group is questionable. They are called the Huertle cell tumors and may be either benign or malignant. The large, eosinophilic staining cells thought to be characteristic of this type of growth are found in a number of conditions unrelated to the tumor, such as Hashimoto struma, simple hyperplasia and myxedema. Some investigators have proposed that this cell type is not *per se* of sufficient significance to make a separate classification since they think it may occur in simple adenomas. Certainly such Huertle

tumors probably are not in any way related to the interstitial cells observed many years ago by Huertle in the thyroids of young dogs. However, like the designation "hypernephroma," long clinical application of the term has made it a distinct entity although better terms would probably be "acidophilic adenoma" and "acidophilic carcinoma." These tumors are less likely to show the hemangio-invasive tendency than the fetal adenomas. They, too, on cross section ordinarily are seen to be brown, cellular growths and often show an admixture of tumor nodules interspersed with normal appearing thyroid tissue without appearing to actually infiltrate the surrounding gland. Histologically, the tumor is found to be made up of acini and columns of cells lined by columnar or rather large cuboid cells which have a striking acidophilic, often granular cytoplasm (fig. 4). The nuclei are

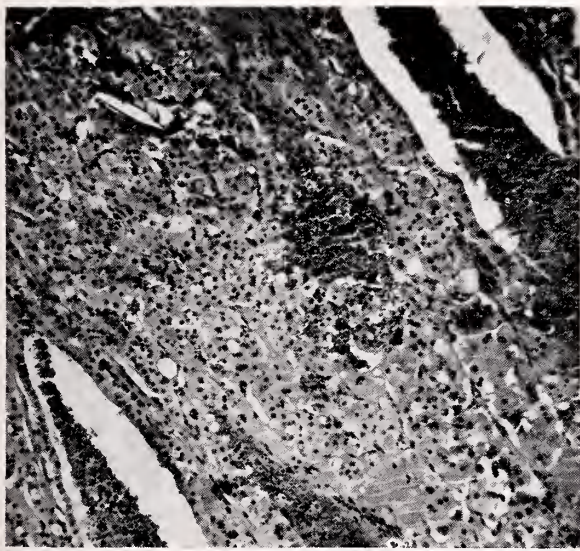


Fig. 4 Thyroid Huertle cell tumor or acidophilic adenoma showing large pale acidophilic cells and interstitial hemorrhage. (Low power)

often deeply basophilic and may show serration of their borders. Hemorrhage is not at all uncommon and deposits of hemosiderin may be found as the result of old small hemorrhages. When carcinomatous transformation takes place, we see the usual nuclear variants with definite invasive tendencies, and vascular penetration may be found in some of the more rapidly growing specimens.

The next group of benign and malignant tumors which I have chosen to separate from the foregoing are the papillary cystomas and

papillary carcinomas. As Graham⁵ showed many years ago and as has been repeatedly emphasized in the past few years by different writers, when such cystomas become malignant they extend regionally by lymphatic channels. These have been captioned by Crile and others as the "lymphangio-invasive" tumors. In contradistinction to the adenomas, they are either indefinitely or non-capsulated and the capsule which appears to be present in some zones may be a simple, irritative, reactive fibrosis. For some years when metastatic deposits were found in the cervical nodes, they were thought to have arisen in lateral aberrant thyroid rests. However, continued investigation of these tumors has satisfied most workers that usually always a hidden focus of malignancy exists in the thyroid gland when such a gland grossly may not show the primary source. The great majority of these tumors occurs in children and young adults as opposed to the other carcinomas which appear in most instances in adults and older people. Sometimes the excessive papillary hyperplasia observed in nodular goiter which is undergoing proliferation in large degenerating follicles, may be confused with true neoplastic overgrowths (fig. 5). When these tumors are benign his-

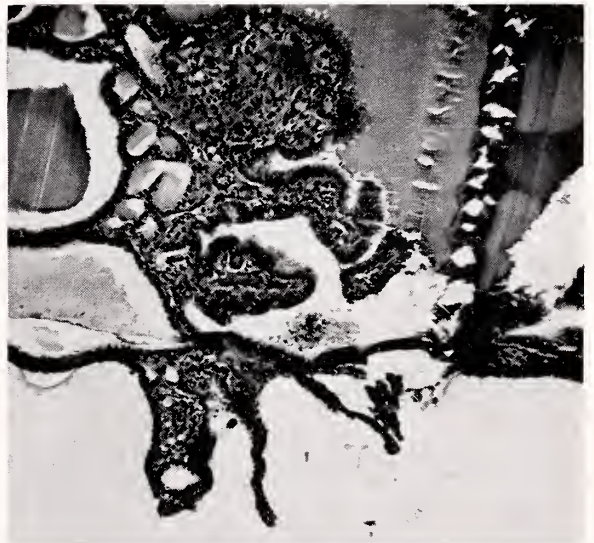


Fig. 5 Degenerating colloid goiter showing papillary hyperplasia in degenerating follicles. (Low power)

tologically, we see long, filliform, arborizing papillations covered with well differentiated, cuboid or columnar cells with very little tendency toward anastomoses and secondary

acinar formation, and little or no sign of invasion (fig. 6). When penetration is observed,

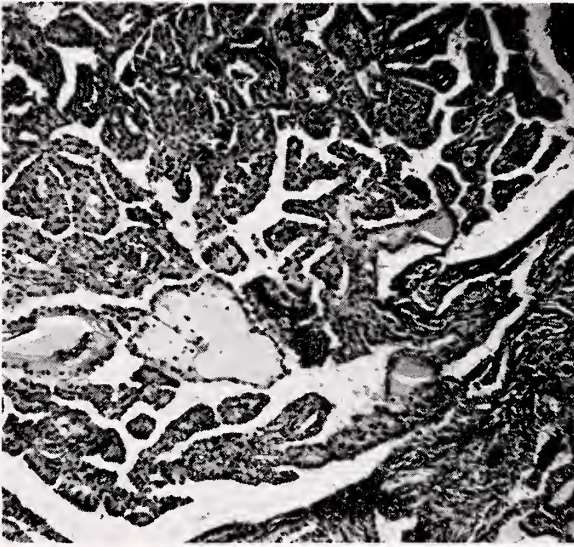


Fig. 6 Thyroid showing benign papillary cystoma; note branching and anastomosing processes lined by low regular cuboid cells. (Low power)

if the tumor is clinically malignant we will see changes in cell type and a marked tendency in many areas to the formation of secondary, slightly to moderately atypical follicles with an added feature that solid masses of cells are usually observed (figs. 7 and 8). When the tumor has metastasized

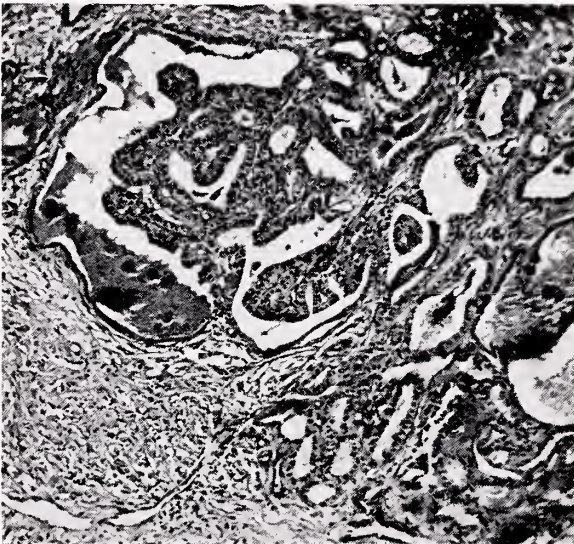


Fig. 7 Thyroid showing invasive papillary growth with penetration into connective tissue of low grade malignancy. (Low power)

to the neck nodes, they may almost completely replace it and we will see the picture of papillary stalks covered by cuboid or higher



Fig. 8 Low grade papillary carcinoma of the thyroid. Observe tendency to more or less solid type of growth with slightly atypical glands and anastomosis of papillations. The cell type is fairly regular. (Low power)

epithelium and occasional small irregular masses of cell unaccompanied by a stalk. Oftentimes such stalks show considerable edema (fig. 9). Such tumors are very fre-

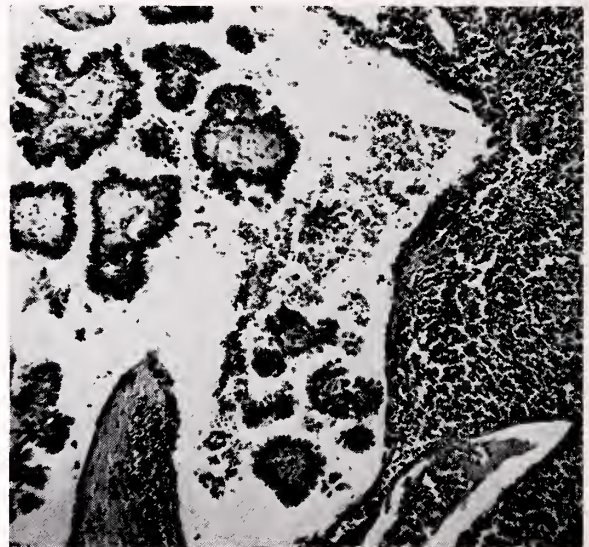


Fig. 9 Metastatic lesion in cervical lymph node showing edematous papillary stalks. (Low power)

quently curable by neck dissection and rarely yield metastases beyond the regional nodes until very late. I know of several patients with extensive involvement of superficial and deep nodes who have remained well for many years following surgery. Unlike other cancers of the thyroid, these tumors usually are found to be sensitive or moderately sensitive

to external irradiation. Hence, it has been suggested by some investigators that when the gland alone is involved, without palpable regional node dissemination, and the capsule of the thyroid gland is intact, that after thyroidectomy external irradiation will take care of any possible miniature metastatic foci in the lymph nodes. Others recommend neck dissection.

Adenocarcinoma may begin either as a localized lesion or as an apparent diffuse growth throughout one or both lobes of the gland. It may be a pure adenocarcinoma or show papillary tendencies. The gland becomes hard, indurated, and may produce symptoms of compression. It usually appears in individuals past 40. The follicles are variable in size and are lined with atypical epithelial cells which produce considerable reactive neoplastic fibrosis in many areas. This tumor, like the malignant fetal adenomas, may metastasize by way of the blood stream and not infrequently it breaks through the capsule of the thyroid and invades surrounding structures. These tumors may constitute a very difficult problem in microscopic diagnosis in their early stages when they are completely confined within the capsule of the gland. It is quite possible that many of the so-called adenocarcinomas, which reveal only moderate cell variants although involving wide areas of the gland, are clinically benign although histologically sufficiently atypical to be considered malignant. I have frequently been puzzled by this type of growth. Perhaps I have been too conservative, or I may have been too optimistic, in disregarding moderate morphologic variants and classifying these growths among the benign hyperplasias. It has often been my misfortune to see patients who have had a diagnosis of cancer of the thyroid rendered on such cytologic evidence in whom a cancer phobia has been produced, making the patient an anxious psychotic for years.

The other carcinomas of the thyroid are all frankly malignant, clinically and microscopically. Among these are the polymorphous cell, the small diffuse round cell, the giant cell and the spindle cell varieties together with rare instances showing atypical squamous metaplasia and called squamous cell carcinoma. These glands, like the others, are hard and, depending on cytology, grow

steadily and often rapidly. The polymorphous cell tumors show marked variants with striking deformity of nuclear structure, hyper- and hypochromatism, bizarre atypical nuclear structures, mitoses, giant figures (fig. 10), etc. Spindle form growths resemble

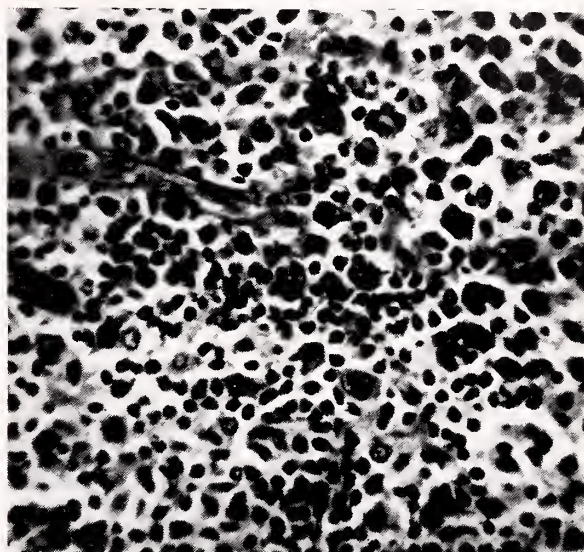


Fig. 10 Polymorphous cell carcinoma of the thyroid; observe immaturity of cells and hyperchromatism. (High power)

ling spindle cell sarcoma are also observed. Depending upon the predominance of such structures, they may be divided into the polymorphous spindle form or giant cell groups. The spindle form tumor has been the subject of considerable controversy among pathologists, Ewing being one of the early writers to insist that such tumors were of epithelial origin. Moreover, occasional well capsulated adenomas are sometimes seen with this spindle form structure (fig. 11). The diffuse, small cell type is often very rapidly growing and on section reveals a pale, grayish white cut surface. Cytologically the tumor resembles lymphosarcoma or reticulum cell sarcoma and some pathologists of high scientific attainments have disagreed as to their epithelial origin. Occasionally small groups of cells suggesting nests of epithelium are encountered and the gland usually has been completely replaced by the diffuse growth, only a little follicle being present here and there to show the origin of the tumor. I have always felt that these tumors were of epithelial origin because of their usual high resistance to external irradiation. These tumors



Fig. 11 Spindle form type of solitary, well capsulated adenoma of the thyroid. (Low power)

invade nodes, extend widely locally, ulcerate and metastasize as well by the blood stream.

Lastly, we have the so-called "benign metastasizing goiter," first described by Cohnheim in 1876.⁶ Simpson's study⁷ of 77 reported cases, adding three of his own, recorded two instances reported by Zapelloni⁸ wherein no signs of goiter or thyroid malignancy were present clinically, and Allesandri⁹ mentioned several similar instances which he encountered in the literature and added two of his own. These unusual cases have led to a great deal of speculation when no detectable changes were found in the thyroid and yet metastatic deposits were present. Three explanations of the pathogenesis of such rare growths have been advanced. First, that of misplaced embryonal rests, which has also been advanced to account for rare adamantinomas in the long pipe bones. Second, normal thyroid tissue may break into the blood stream and be carried to bone, setting up a new growth. Gaylord¹⁰ observed such an event in fishes, and Riedel¹¹ and Oderfeld and Steinhaus¹² observed it with thyroid tissue. However, most writers on the subject have considered that the most logical explanation is a miniature malignant adenoma which was overlooked at the time of thyroidectomy or necropsy. I have observed one such case¹³ in which no palpable nodule was ever encountered in the thyroid and the deposit in the humerus appeared relatively innocent histologically (fig. 12). Biological

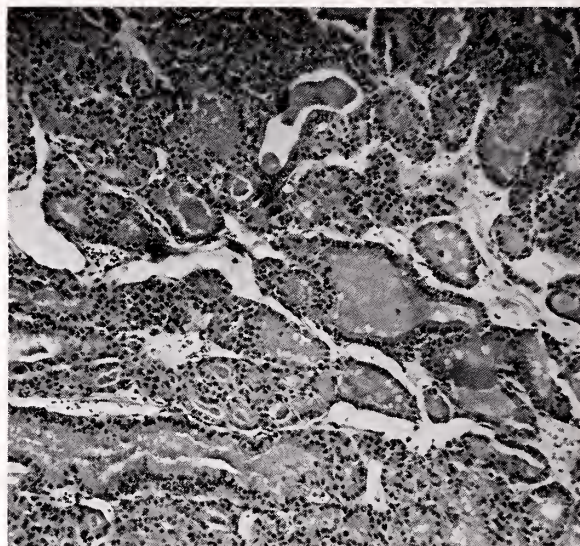


Fig. 12 "Benign metastasizing goiter" removed from head of humerus. (Low power)

assay with dessicated tumor from the humerus metamorphosed tadpoles and decreased the toxicity of acetonitrile for mice. Shoulder joint amputation, however, failed to effect a cure and three and a half years after disarticulation of the arm at the shoulder a massive growth recurred. Signs and symptoms of very acute thyrotoxicosis developed from which the patient died, and microscopic examination of the tumor at the time of death showed a more undifferentiated growth than the original. At the time of death, however, slight lobulation of the thyroid was palpable but the gland was freely moveable. Unfortunately, we were unable to procure permission for anything but a piece of the recurrent lesion on the shoulder.

Most sarcomas of the thyroid, described by the older writers, have, as previously indicated, been absorbed into the epithelial group. Certain very rare tumors are so uncommon as to be curiosities and of little clinical significance.

BIBLIOGRAPHY

1. Graham, A.; Surg., Gynec. & Obst. 39:781, 1924.
2. Graham, A.; Ann. Surg. 82:30, 1925.
3. Clute, H. M. and Warren, S.; Surg. Gynec. & Obst. 60:861, 1935.
4. Crile, G., Hazard, J. B. and Dinsmore, R. S.; Transactions of the American Goiter Association; Charles C. Thomas, Springfield, Ill.; p. 159, 1949.
5. Graham, quoted by Crile et al, Ref. 1, p. 160.
6. Cohnheim, Jul; Arch. f. path. Anat., LXVIII, 547, 1876.
7. Simpson, W. M.; Surg. Gynec. Obstet. XLII, 489, 1926.

(Continued on Page 131)



PRESIDENT'S PAGE

L. J. Pankow, M.D.

May Message

I have had opportunity, during this past year, to test the theory that there is much to be gained from attending medical meetings. I believe the theory is correct. I have found a four fold gain, but there are probably more.

In the first place, there is the gain of listening to a talk by some other doctor. Whatever the subject, there is some gain in it in the presentation or in the discussion that will help me at some future time. Some of them are very helpful in my everyday work.

Secondly, I meet men that I do not see very often. They may be from my own area, but men I do not meet in my hospital rounds or daily work. Some of them are from towns near me, and others are from a considerable distance. They will talk about something which gives me a chance to get better acquainted with them. I try to sit near someone whom I have not been with for a long time, and so manage to find his point of view on things. I may get some new ideas, or I may be able to convert him to some of mine. Whatever the reason, it is nice to meet and renew old friendships, and to make new ones.

Thirdly, if the meeting has exhibitors, I am able to find new ideas of instruments or medicines to help me. Maybe it is a new and simple method of doing a laboratory test, or a new type of stethoscope that helps my aging ears better to pick up body sounds. Maybe it is a new book that is just what I have been looking for. Or maybe the gain will be a new key container or some hand lotion to take home to the wife.

Fourthly, it affords me a respite from the daily gripes of patients, and of having to stay on my toes to keep ahead of their ailments. One does get mighty tired, at times, from seeing patients all day long, in the hospitals, in their homes, and in the office, and then when one finally does get to bed, have a patient call, who has been sick all day, but waited until after midnight to be sick enough to need a doctor. These will not gracefully accept a refusal to make such a call, but if they are told that you are out of town attending a medical meeting, they will usually manage to stay alive until you get back. And they don't hold it against you because you were away learning something for their good. And there is a mighty nice feeling to crawl in between sheets in a room where the telephone is there for your convenience and not as an instrument of torture to be used on you at 2 or 3 A.M.

There are undoubtedly many other good reasons for getting to medical meetings as often as you can. Whatever they be, they are all good for you. For your health's sake or to improve yourself for taking better care of your patients, attendance at these meetings is good for you.

But there is nothing, medicine or other, that, taken in overdosage, does not cause some undesired side effect. I am fast getting to the overdosage point in this my year as your president. Truly I am glad that it is getting nearer to the time when some of the great values and benefits I have mentioned in this message, will be able to be put to use in the practice of medicine again, in my own office and on my own patients. It has been fun, lots of fun, but I suppose one could even get tired of fishing, too.

Maybe not, tho.

EDITORIAL PAGE

ATTENDANCE AT MEDICAL MEETINGS

Every physician should attend all the medical meetings that he possibly can. The time and money that he spends in this manner is well worth-while, and it is absolutely necessary if he desires to keep abreast of the times in medical matters and give his patients the best service. Even though one may not have a special interest in the subject presented by the speaker one can always pick up a few pointers which will be valuable some time.

No matter how many medical journals and books a physician reads and studies it is usually more impressive and instructive to hear the points on any particular subject as they come directly from the lips of the speaker who is a master in his field. Lantern slides, diagrams, movies, and so on, help to make modern medical lectures more valuable to those present.

It is especially important to have a large attendance at a meeting of the State Medical Association. The Program Committee goes to considerable trouble to arrange a program including topics of current interest. Outstanding speakers are brought from considerable distances and the members owe them the courtesy of having a large number present to listen to their lectures.

Attending the Annual convention also gives members a chance to renew friendships with professional colleagues. Another reason for having annual sessions is to help members become better acquainted with their Association and every physician who attends should remember that an informed member of the organization is a strong member of the organization.

However, while the business and social activities of a State Medical Convention are important, we must always remember that the main purpose of a medical meeting is the Scientific Session and a large attendance is necessary to make this part of the program a success.

R. G. M.

GULLIBLE'S TRAVELS

Gullible has a full month's travels to report in a short space. On March 22, I rode at ease with our Association President, **Dr. Pankow** to Mitchell to attend the Mitchell District Medical Society meeting at the Country Club. The meeting was one of the best attended in recent years of that district. This was the president's official visit and an opportunity for me to discuss the recent legislative session.

The following week was spent in the office. Tuesday the 27th, **Dr. David Gregory**, president-elect of the Association was in and discussed business to come up during the next fiscal year.

Wednesday, **Dr. A. P. Peeke** came in from Volga to discuss the progress of the health survey which is now in the hands of the printer. Had lunch with Dr. Peeke, his wife and daughter at the LeElbon.

The next noon, which was the 29th. Gullible spoke at the Sioux Falls Junior Chamber of Commerce luncheon, discussing legislative activities.

Saturday night, despite high winds and icy roads, my wife and I were able to attend the Annual Medical School Dinner Dance at the University in Vermillion.

The following week was one filled with office work, mainly preparations for the Annual Meeting, until the weekend. On Saturday morning, accompanied by **Rev. Ben Genvik** of Lutheran Welfare, I journeyed to Pierre to sit in on a meeting of the steering committee which is paving the way for this administration's version of the Governor's Committee on Children and Youth. That evening I met with **Drs. Geib, Saxton, and Buchanan** in Huron to discuss activities of their committee on Hospitals and Medical Education.

The next morning saw me back in Pierre for a meeting of the association's Liason Committee with the State Dept. of Health. Representing the Association were **Dr. Geib**,

(Continued on Page 130)

Paper Titles For Annual Meeting

- "An Improved Technic for the Operative Treatment of Common Anorectal Lesions" — Film.
- "Acute Abdomen" — Philip Thorek, M.D.
- "Congenital Abnormalities of the Urinary Tract in Children" — Edith Potter, M.D.
- "Some Interesting Highlights of Orthopaedic Practice" — Fremont Chandler, M.D.
- "Intestinal Obstruction" — Philip Thorek, M.D.
- "Tracheotomy and Bulbar Poliomyelitis" — Robert E. Priest, M.D.
- "Backache, Its Diagnosis and Treatment from the Standpoint of the General Practitioner" — Carlo Scuderi, M.D.
- "Bronchogenic Carcinomas Simulating Benign Lesions" — C. Allen Good, M.D.
- "Carcinoma of the Prostate Gland" — Wm. J. Baker, M.D.
- "Aureomycin — Versatile Antibiotic" — Film.
- "Renal Tumors" — Wm. J. Baker, M.D.
- "Conduct of Abnormal Labor" — J. H. Randall, M.D.
- "Eruptive Diseases of a Contagious Nature" — Archibald L. Hoyme, M.D.
- "Medical Care of Cardiac Patients Undergoing Surgery" — R. D. Pruitt, M.D.
- "Liver Biopsy" — M. H. Stauffer, M.D.
- "Malignancy of the Female Genital Tract" — J. H. Randall, M.D.
- "Anxiety in Pediatrics" — Reynold A. Jensen, M.D.
- "Malignancy of the Skin" — C. W. Laymon, M.D.
- "The Academy of General Practice" — Mac F. Cahal.
- "The Rationale and Technique of Endocrine Replacement in the Aged Female, and a Preliminary Result Report" — W. H. Masters, M.D.
- "Head Injuries" — Roland M. Klemme, M.D.
- "X-Ray Analysis of the Pelvic in Pregnancy" — B. S. Kalayjian, M.D.
- "How Much Should a Physician Earn" — Frank G. Dickinson, Ph.D.

This is



MAY
1951
Vol. 4 No. 5

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Guest Speakers To Be Heard At Annual Meeting, June 4-5-6



ENDOCRINE REPLACEMENT IN AGED FEMALES IS SUBJECT

"The Rationale and Technique of Endocrine Replacement in the Aged Female, and a Preliminary Result Report" has been selected as the subject of a paper to be presented by W. H. Masters, M.D., of the Washington University School of Medicine.

Dr. Masters who has been working for sometime on the research connected with this problem, is Associate Professor in Obstetrics and Genecology at the St. Louis school. In addition he is consulting Genecologist to the St. Louis City Infirmary and

the Marine Hospital.

He will appear on the program on Wednesday June 6 at 9:30 a. m.



SKIN MALIGNANCIES LAYMON SUBJECT

Dr. Carl W. Laymon, Minneapolis will present a paper on malignancy of the skin at 4:00 p. m. Tuesday June 5 during the seventieth annual meeting of the South Dakota State Medical Association.

Dr. Laymon is a graduate of the University of Minnesota, receiving his M.D. in 1930 and his Ph.D. in dermatology in 1934. He is presently Clinical Professor of

Dermatology at the University of Minnesota and Director of the Department of Dermatology at Minneapolis General Hospital.

MAYO RADIOLOGIST TO TALK ON CANCER

Dr. C. Allen Good, Mayo Clinic, Rochester, Minnesota, will present a paper at the Annual Meeting titled, "Bronchogenic Carcinomas Simulating Benign Lesions."

Dr. Good is a Fellow in the American College of Radiology and is Associate Professor of Radiology Mayo Foundation at the University



of Minnesota. He is also consultant to the Section on Roentgenology at the Mayo Clinic in Rochester.

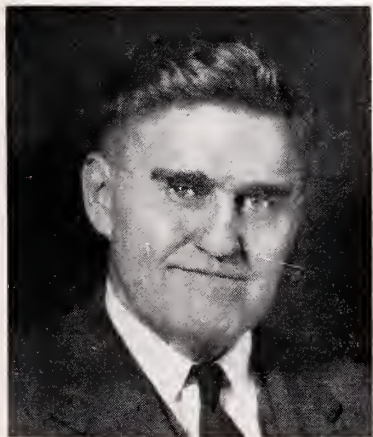
In addition to the presenta-

tion of the paper on the Monday afternoon program Dr. Good has been invited to act as guest discussion leader at the luncheon meeting of the South Dakota Academy of Radiologists.

**AMA ECONOMIST
TALKS ON DR. INCOME
AT ANNUAL SESSION**

Frank G. Dickinson, Ph.D., Director of the Bureau of Medical Economic Research of the American Medical Association, will use as his theme, "How Much Should a Doctor Earn" in presenting a paper at the Seventieth Annual Meeting of the South Dakota State Medical Association. Dr. Dickinson will appear on the program Wednesday afternoon June 6.

Dr. Dickinson is a native of Illinois, receiving his A.B. degree from the University of that state in 1921. In 1923 he received his Masters degree from Pennsylvania State College and received his Doctor of Philosophy at the University of Illinois in 1927. He taught Economics, specializing in Insurance and

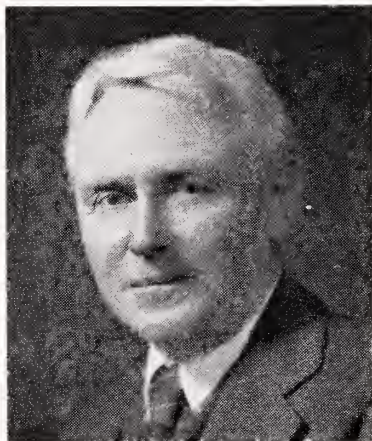


Statistics from 1921 through 1946 with the exception of he year at Penn State.

He is the inventor of the Dickinson Football Rating System which is still widely used throughout the country. Dr. Dickinson will speak on doctor's income basing his information on statistics gathered over the last several years while in his position as Director of the AMA Bureau.

**HOMESTAKE PRESIDENT
IS BANQUET SPEAKER**

Highlighting the 70th Annual Banquet of the South Dakota State Medical Association to be held at the Aberdeen Country Club at 7:00 P.M. June 4, will be Donald H. McLaughlin, Ph.D., San Francisco, president of the Homestake Mining Company. His subject will be "Gold."



Dr. McLaughlin, in addition to holding the presidency of the Homestake Mining Company, is a director of the Empire Trust Company, the Triumph Mining Company, the Dorr Company, the American Trust Company, the Cerro de Pasco, and the Bunker Hill and Sullivan International Nickel Co. He is a graduate of the University of California and received his A.M. and Ph.D. from Har-

vard University. At various times he has been Dean of the Colleges of Mining and Engineering at the U. of California and the professor of Geology at Harvard in addition to consultants' work with many mining and engineering organizations.



**IOWA UNIVERSITY
OB-GYN HEAD
ON ANNUAL PROGRAM**

J. H. Randall, M.D., Head of the Department of Obstetrics and Gynecology at the University of Iowa Medical School, will present two papers during the Annual Meeting to be held in Aberdeen.

On Tuesday, June 5 at 10:00 a. m. he will talk on "Conduct of Abnormal Labor" and at 2:30 that afternoon will speak on "Malignancy of the Female Genital Tract."

Dr. Randall is a graduate of Iowa University Medical School where he also interned and he has done graduate study at the University of Vienna in Austria. He has been Professor of OB and GYN since 1944 and recently was named Acting Head of the Department.

TWO UROLOGY PAPERS FEATURE OF SESSION

William J. Baker, M.D., Chicago urologist, will present two papers in his specialty at the Annual Meeting of the South Dakota State Medical Association in Aberdeen. Dr. Baker's first paper titled "Carcinoma of the Prostate Gland," will be presented at 4:00 p. m. Monday June 4.

His second paper "Renal Tumors" will be presented the following morning at 9:30.

Dr. Baker is Associate Professor of Urology at Northwestern University Medical School, Senior attending urologist at St. Luke's Hospital, Chief of the urological service at Cook County Hospital and head of the department of urology in the Cook County Post Graduate School.

Dr. Baker's appearance on the Annual Meeting program is being sponsored by the South Dakota division of the American Cancer Society.



**CARLO SCUDERI, M.D.
TO PRESENT TALK
ON BACKACHE**

Carlo Scuderi, M.D., Chicago, Associate Professor

of surgery at the University of Illinois and Senior Attending Surgeon at Cook County Hospital will present a paper at the 70th Annual Meeting titled "Backache, Its Diagnosis and Treatment from the Standpoint of the General Practitioner."

Dr. Scuderi is Chairman of the Department of Orthopedic Surgery at St. Elizabeth and Columbus Hospitals in Chicago and is a certified member of the American Board of Orthopedic Surgery.



**EX-SOUTH DAKOTAN
IS PROGRAM SPEAKER**

Bernard S. Kalayjian, M.D., of the Department of Radiology, Woman's Hospital, Detroit will speak on "X-Ray Analysis of the Pelvis in Pregnancy" at the Annual Meeting in Aberdeen. Dr. Kalayjian was born in Parker, South Dakota and was educated at Yankton College, University of South Dakota and Rush Medical College. He interned at Presbyterian Hospital in Chicago. He became Radiologist at Woman's Hospital in 1946.



**PRES.-ELECT, AMERICAN
ORTHOPAEDIC ASS'N TO
APPEAR ON PROGRAM**

Fremont A. Chandler, M.D., Professor of Orthopaedic Surgery, University of Illinois will speak on "Some Unusual Problems Arising in the Course of Orthopaedic Practice," June 4.

Dr. Chandler is also Senior Attending Orthopaedic Surgeon, St. Luke's Hospital, Chicago, and president-elect, American Orthopaedic Association.



**PEDIATRIC ANXIETY
JENSEN SUBJECT**

Reynold A. Jensen, M.D., Assistant Professor of Pediatrics and Psychiatry at the University of Minnesota School of Medicine, is sched-

uled to speak on the program for Tuesday, June 5.

Dr. Jensen is a graduate of the University of Minnesota, School of Medicine; post-graduate work at the University of Rochester Medical School-Assoc. Res. Medicine (Psychiatry); Pennsylvania Hospital-Philadelphia and Judge Baker Guidance Center, Boston, Mass.



CHICAGO PATHOLOGIST TO SPEAK ON PROGRAM

Edith L. Potter, M.D., Associate professor of pathology in the department of obstetrics and gynecology and pathology, the Chicago Lying-in-Hospital will speak on "Congenital Abnormalities of the Urinary System" for a late morning appearance June 4.

Dr. Potter graduated from the University of Minnesota and took Postgraduate study in Vienna.

She is a member of the American Association of Pathologists and Bacteriologists, Society for Pediatric Research, American Pediatric Society, and American Society of Human Genetics.

NEWS NOTES

Dr. Donald Slaughter, Dean of the S. D. U. Medical School has been appointed a consultant to the Army Medical School. He will present two papers at the school this spring.

* * *

The State Society of Nurse Anesthetists met in Yankton Saturday, April 21.

* * *

Dean Donald Slaughter presented a paper on "The Toxicity of Local Anesthetics" at a meeting of the Federated Societies For Biology and Medicine in Cleveland on April 27.

* * *

J. C. Foster, executive-secretary of the SDSMA has been appointed to the nominating committee of the Medical Society Executives Conference which will meet June 11 in Atlantic City.

* * *

The Board of Clinical Chemistry will meet in Chicago May 25 and 26 to consider over three hundred applications for certification.

* * *

Eli Lilly Co. of Indianapolis is enlarging its facilities for research for the fourth time. The new addition is a three story, 204 foot affair.

* * *

The South Dakota Heart Association held its first meeting in Pierre with **Dr. D. L. Kegaries** of Rapid City presiding.

Curt Rosenbaum, M.D., psychiatrist with the Veteran's Administration transferred from Lancaster County, Nebraska, to the Seventh District Society.

F. P. Marturano, M.D., Veteran's Administration, Sioux Falls, shortly after receiving membership, transferred to Denver, Colo.

Dr. Magni Davidson, Brookings, represented the Third District at the National Convention of the American Academy of General Practitioners in San Francisco in March.

Dr. E. H. Grove, formerly of Arlington has retired and is now in Austin, Texas.

* * *

Three members of the staff of the Department of Anatomy, School of Medicine, at the University of South Dakota returned to Vermillion after attending meetings of the American Association of Anatomists and affiliated groups at Detroit. The trio are Doctors **Earl B. Scott**, **H. J. Clausen**, and **Walter L. Hard**. Dr. Scott and, Dr. Hard presented papers dealing with results of research carried on in the department during the past year.

* * *

The United States Public Health Grant in support of research presently held in the department of anatomy has been extended in time to August, 1952, according to **Doctor W. L. Hard**, Chairman of the Department of Anatomy, who is directing research on this grant.

The original grant was in the amount of \$5,000 for the support of work dealing in particular with the study of the localization and distribution of certain chemical constituents of nerve tissue which can be identified by microscopical techniques. Both normal and pathological tissue is being examined to

better understand the role of these chemical constituents in disease processes.

* * *

The following is a list of physicians in the state of South Dakota who registered at the 14th annual meeting of The New Orleans Graduate Medical Assembly, which was held March 5-8.

Dr. Y. H. Charbonneau
Huron
Dr. Wm. A. Delaney
Medical Arts Building
Mitchell
Dr. Floyd D. Gillis, Jr.
220-224 Realty Bldg.
Mitchell
Dr. Carlos E. Kemper
Viborg
Dr. J. E. Mannion
Gregory
Dr. Paul R. Scallin
Redfield
Dr. V. R. Vonburg
Mitchell

BLACK HILLS DISTRICT HEARS TWO SPEAKERS

The Black Hills District Medical Society met at the St. Johns McNamara Hospital in Rapid City on April 19. The afternoon meeting chairmanned by **Dr. A. A. Lampert**, president, was the setting for presentation of two scientific papers.

The first presentation was by **Dr. Donald L. Kegaries** who spoke on water balance. This paper was discussed by various members of the society.

Dr. R. E. Jernstrom spoke of injuries of the ankle which was followed by a discussion by **Dr. F. R. Williams**.

John C. Foster spoke on the recent legislative session.

Dinner was served by the hospital staff, the meeting ending about 5:30 P.M. Ap-

proximately forty members were present.

GP GROUP MEETS IN HURON CONFAB

The South Dakota division of the American Academy of General Practice held its second meeting in Huron at the Marvin Hughitt Hotel. **Faris Pfister, M.D.**, Webster, presided at the meeting which was attended by more than twenty General Practitioners.

New members admitted to the South Dakota Chapter were **Drs. E. R. Schwartz**, Wakonda; **F. D. Leigh**, Huron; **Hamlin Graham**, Chamberlain; **Merritt A. Auld**, Yankton; **Clark F. Johnson**, Yankton; **Roland F. Hubner**, Yankton; **E. T. Leitzke**, Beresford; **C. L. Voge**, Aberdeen; **M. R. Gelber**, Aberdeen; **J. A. Eckrich**, Aberdeen; **Paul R. Scallin**, Redfield; **N. E. Wessman**, Sioux Falls; **A. W. Kilness**, Sioux Falls; **W. L. Opheim**, Sioux Falls; **M. O. Lanam**, Sioux Falls; **M. C. Tank**, Brookings; **Walter H. Patt**, Brookings; **D. C. Austin**, Brookings.

ABERDEEN DISTRICT HEARS DR. COUGHLIN

The Aberdeen District Medical Society met Wednesday, April 11, at the Sherman Hotel to hear a paper by **Dr. Bertrand Coughlin**, Minneapolis, on "Proctologic Diseases as seen in the Office."

Dr. A. P. Reding, Marion, and **Dr. Wm. Duncan**, Webster, were guests at the meeting.

Mrs. A. P. Reding, Marion, President of the State Auxiliary, met with the wives of Aberdeen doctors to discuss plans for the Auxiliary meeting in June.

SEVENTH DISTRICT HEARS BISGARD

"Indications for Pneumotomy" was the subject by **Dr. J. Dewey Bisgard** and **Donald F. Rayl** of Omaha at the regular meeting of the Seventh District Medical Society at the College, April 3.

NEW COMMITTEE ON CRIPPLED SET

A Medical Advisory Committee for the Crippled Children's Hospital and School which will serve east-river South Dakota has been selected to represent the State Medical Association in the planning of the operation of the institution which is scheduled to open late this fall.

Dr. L. . Pankow, president of the association, has named **Dr. Guy E. Van Demark**, Sioux Falls, chairman; and **Dr. J. D. Alway**, Abbeeden; **Dr. W. H. Saxton**, Huron; **Dr. W. H. Karlins**, Webster; **Dr. M. C. Tank**, Brookings; **Dr. G. J. Van Heuvelen**, Pierre; and **Dr. Emil Ericksen**, **Dr. John McGreevy**, **Dr. Don H. Manning**, and **Dr. C. W. Ihle, Jr.**, Sioux Falls.

The advisory committee, which was appointed at the request of the Crippled Children's Hospital and School organization, is charged with advising on the selection of key personnel, setting standards for admission and discharges, providing of proper medical supervision, and creating a better understanding of the non-profit organization through-out the state.

While carrying the term "hospital," the new institu-

tion is primarily a school with physical care while in attendance. There will be no surgery or acute medical services, but rather examination, convalescent and treatment care.

The institution has no denominational, fraternal or governmental affiliation, being an independent corporation owned by nearly 40,000 contributors and governed by a board of directors of 21 members.

POSTGRADUATE COURSE IN ALLERGY PLANNED

The Postgraduate Course in Allergy, which is to be given in Montreal, will take place just prior to the meetings of the Canadian Medical Association in this city. It is designed to cover recent advances in the fields of applied immunology, biochemistry, and in particular, endocrine relations as they relate to the field of allergy. It will be augmented by the use of clinical material, as well as charts and demonstrations. It is expected that there will be adequate opportunity for round-table discussion and question periods.

Registration Applications may be sent to Bram Rose, M.D., McGill University Clinic, Royal Victoria Hospital, Montreal. Applications should be received by June 11, 1951. The fee will be \$40.00.

Meeting Place The Course will be given in the Amphitheatre of the Montreal Neurological Institute, June 14, 15, 16, 1951.

It is suggested that hotel

reservations be made individually at any one of the following hotels: Ritz-Carlton Hotel, Sherbrooke Street West (single, \$7.50 up, double \$11.00 up); Laurentien Hotel, Windsor Street (single, \$4.50 up, double \$7.50 up); Mount Royal Hotel, Peel Street (single, \$5.00 up, double \$8.00 up); Windsor Hotel, Peel Street (single \$5.00 up, double \$8.00 up).

FIRST ANNUAL MEDICAL SEMINAR

Physicians and surgeons throughout this country and Cuba are being invited to attend the First Annual Medical Seminar of Mount Sinai Hospital, Miami Beach, Florida. The event will be held on May 23rd, 24th and 25th, 1951, at the Sorrento Hotel in Miami Beach.

A.M.A. MEETING TO FEATURE ANNUAL ART EXHIBIT

The American Physicians Art Association will have an art exhibit, as usual, during the A.M.A. convention at Atlantic City, N. J. June 11 to 15, 1951, inclusive. Any physician in the United States, Canada and Hawaii desiring to participate in this show should communicate with the secretary for particulars.

J. Henry Helser & Co., Inc., Investment Managers with offices on the Pacific Coast, are the new sponsors of the American Physicians Art Association and will award 200 trophies besides a special Helser Trophy — a large decorative cup depicting Yankee Ingenuity. This cup is to be

awarded for art work done in any medium. Also the large Popularity Trophy will be awarded to the owner of the art piece receiving the most popular votes during the A.M.A. convention. Over 4,000 members of the American Physicians Art Association will receive shortly, entry blanks, shipping labels and rules about this fourteenth art exhibition.

The Annual Art Banquet will be held Tuesday evening, June 12 at the Marlborough-Blenheim Hotel, Atlantic City, N. J.

WESTERN INSTITUTE ON EPILEPSY

The date of the Third Western Institute on Epilepsy which will be held in Salt Lake City has been changed from the weekend of June 15-17 to the weekend of June 22-24, 1951.

ARMOUR BUILDING TEXAS BLOOD PLANT

At the request of the Army, Armour and Company began building a new blood-processing plant at Fort Worth, Tex., Monday, March 7.

The plant, in which The Armour Laboratories will produce dried human blood plasma for the Army under an Army contract, will cost approximately \$850,000. Eventually it is expected to handle up to 15,000 pints of blood a month. It is the only such plant in the southwest, though the Army has set up similar plants under private operation in other parts of the country.

PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor

NEWS NOTES

Jerry A. Miller, Vermillion, S. D. Pharmacist, died on Friday, April 13th. Jerry was born at Lennox, S. D., October 15, 1890. He operated a drug store at Tripp for several years and after selling it worked at Davis Pharmacy for a number of years. He is survived by his wife of Vermillion and one son, Dr. Jerry Miller, Detroit, Michigan, and four brothers and one sister.

Henry J. Werner, Ramona, S. D. pharmacist, died at Rochester on March 27th following surgery a few weeks before. Besides being pharmacist Mr. Werner had been a mayor of Ramona and was postmaster from 1933 to 1950. He was born at Ossian, Iowa, December 7, 1879, and spent his boyhood there. He was graduated from the Highland School of Pharmacy in 1908 and opened his first store at Oelrichs, S. D. in 1910, and later at Roswell and Mitchell before going to Ramona in 1915 to establish the store he operated until his death.

Spiers Drug Store, Milbank has remodeled their store. An invitation is extended to all to stop in for coffee when passing through Milbank.

Carr Ross (State, 51) is managing pharmacist at Hall Drug, Sioux Falls, S. D.

Lt. J. R. (Bob) Vander Aarde (State, 51) is with the Army in Korea. Although still officially in the Infantry he has been assigned to the medical corps for sometime and says he has become quite proficient at giving "shots" of penicillin, etc.

The Annual Pharmacy Institute was held at Brookings on April 2-3-4. The attendance was the best so far and the program was excellent, covering the professional and business aspects of pharmacy as well as the veterinary department. Dean LeBlanc should be congratulated on the improvement of the institute each year. However the attendance should be much better, and I am sure it will be, if the pharmacists who did not attend this

year will talk it over with those who did attend.

REVISED DURHAM — HUMPHREY BILL

The April 2 issue of the N.A.R.D. Journal contains an article as follows:

Representative Carl T. Durham of North Carolina and Senator Hubert H. Humphrey of Minnesota have in response to a request of the N.A.R.D. introduced a revised version of the Durham-Humphrey bill in the 82nd Congress.

The revised version of the proposed measure contains several important changes. Here they are outlined:

(1) The telephoned (oral) prescription may be filled and it is only necessary for the pharmacist to put it in written form and then file it for the record to comply with law. The former provision that required written confirmation from the prescriber within 72 hours has been eliminated.

The simplified procedure is the usual course now followed. Only the telephoned (oral) prescription that calls for restricted amounts of narcotic continues to be illegal since it is contrary to the Harrison Act.

(2) Refills of an original prescription are permissible without authorization from the prescriber unless the specified drugs are restricted under the Food, Drug and Cosmetic Act. If the stipulated drugs are restricted, the pharmacist must procure an oral or written authorization from the prescriber, and if it is an oral authorization, the pharmacist must reduce it to written form for the record. Refills of an original narcotic prescription also as in the case of a telephoned (oral) narcotic prescription violates the Harrison Act.

(3) The Food and Drug Administration will make the decision whether a medicinal is to be sold only on a prescription and the decision is to be based on complete scientific evidence and only after interested parties have had an

opportunity to present their respective views either in person or through a spokesman or in written statement. Then within ninety days after the administrator of the Federal Security Agency has issued an order on the decision he has made, any interested person may carry the decision to a United States Court of Appeals. There the case shall be tried in the nature of an original trial and free of conclusions or inferences in favor of either of the parties to such appeals (company or person) or the Food and Drug Administration. The provision to enable appeals is new and it was added to enable court action in connection with a decision of the Food and Drug Administration to include or to exclude a medicinal from the list of "Legend Drugs."

(4) The administrator of the Federal Security Agency may by regulation remove drugs subject to Section 505 (new drugs) in addition to the drugs subject to Section 502 d (drugs that may lead to addiction) when such requirements are unnecessary for the protection of the public health.

(5) The pharmacist may recognize any prescription from "a practitioner licensed by law" to administer the prescribed drugs. The former provision read: "A physician or dentist licensed by law."

Left unmolested in the revised version is the requirement that the legend must read: "Caution — Federal law prohibits sale or dispensing without prescription." No deviation in the phraseology of the legend is permissible.

The Durham-Humphrey bill in the revised version also continues to confine all drugs to two classes: (1) the drugs which require a prescription and (2) the drugs that may be sold over the counter. Furthermore the only restricted drugs under the Food, Drug and Cosmetic Act are those which substantial evidence shows are unsafe except under the supervision of a practitioner licensed by law to administer such drugs.

The Durham-Humphrey bill in the revised version removes every reasonable objection leveled against the original Durham-Humphrey bill introduced in the 81st Congress.

Of course there will be opposition to the proposed measure even as it is at present. It will come from a minority of pharmaceutical manufacturers and a small group of misguided advocates of the futile lawsuit plan

of the American Pharmaceutical Association.

The minority of the pharmaceutical manufacturers appears, determined to fight for the privilege to use and abuse the legend to serve purposes contrary to interests of the public and the druggists. The law as it is, now allows promiscuous application of the legend. It can be applied to drugs without the slightest scientific justification. Many drugs that carry the legend at present are salable over the counter under various trade names. The resultant confusion is nonsensical. Nevertheless the druggists are compelled to recognize the misplaced legend or they become criminals. The N.A.R.D. seeks to bring about the elimination of this cockeyed situation. Hence the inclusion of the provision that provides for a list of "Legend Drugs." Experience emphasizes that the pharmaceutical manufacturers have long since ceased to be entitled to the privilege to use and abuse the legend. They have made a botch of it and it is time to be done with the mess.

The Durham-Humphrey bill deals with the realities instead of fancies. It accentuates professional responsibility and it continues the protection that Congress intended to insure for the public through the Food, Drug and Cosmetic Act.

The N.A.R.D. has provided a bill that is a practicable and realistic solution of the prescription problem. Now it is up to the druggists to give it strong support. They must write or wire their respective senators and representatives to help pass the Durham-Humphrey bill or the proposed measure will be left untouched in the Interstate and Foreign Commerce Committee of the Senate and of the House.

The Durham-Humphrey bill can be enacted to bring needed relief to the druggists and it is possible to achieve it before too long. Nothing except failure of the druggists to rally in strength behind the proposed measure can block the Durham-Humphrey bill in Congress.

PHYSICIAN-PHARMACIST RELATIONSHIP

The first medicinal practitioners in the American colonies served in the dual role of physician and pharmacist. With rare exceptions, they dispensed their own medicines or

directed relatives and friends of the patient to prepare healing potions from herbs or roots. Later, apothecary shops sprang up in the larger cities, usually as dispensaries of successful doctors, who sometimes sold not only medicines but other items as well, such as spices and teas.

On the basis of an official record of 1646, the first drug store in North America was probably that of William Davice of Boston. By the early 1700's there was a considerable number of apothecary shops or "drug stores" in North America; by 1721 there were 14 in Boston alone. These shops were, in many instances, a sort of primitive medical school, since students commonly began their medical training as apprentices in the apothecary shop of the physician who served as their teacher. Fifty year old Daniel Drake, the first medical student in Cincinnati, for example, began his medical education in the apothecary shop of Dr. William Goforth. James Thomas Flexner, in his "Doctors on Horseback" writing of young Drake's experience, says:

"And what natural boy would not have enjoyed messing 'round in Dr. Goforth's apothecary shop? The most exciting smells rose like incense to the God of physic from brown paper bundles, bottles stopped with worm-eaten corks and open jars of ointment. You mixed the delightful ingredients together with a metal instrument to make powders that you delivered to the sick, running full tilt down the streets of the little town, splashing through puddles rather than going 'round them because you had to be quick, like the pony express. And you knocked on the door of some cabin, with what joy you were greeted by the anxious wife or mother, how eagerly the powder you had prepared was received by frightened hands!"

Daniel Drake later became the leading physician west of the Allegheny Mountains.

Dr. John Morgan of Revolutionary War fame was the first to recommend the complete separation of pharmacy from the practice of medicine. He emphasized that these two professions "certainly require different talents." When it was argued that the separation of medicine and pharmacy would be very inconvenient to most of the American practitioners of the time, Morgan stated: "Practitioners in general business never do, or can

do, the business of an apothecary . . . they have apprentices for the purpose. After visiting the sick, do not their apprentices make up prescriptions? I should ask, if not an apothecary acquired with the art of compounding and making up medicines as skillful in it as an apprentice? Is not a man educated in the profession to be trusted in preference to one who is only learning the business?"

During the Revolutionary War it was established beyond vestige of doubt that pharmaceutical knowledge and pharmaceutical practice were important for public welfare. This demonstration laid the foundation for the establishment of professional pharmacy in the United States.

Today the position of the pharmacist as a professional man of importance is undisputed. The warm relationships so common between physicians and pharmacists are evidence of mutual respect and common interests. In the filling of many prescriptions, the pharmacist literally holds in his hands the physician's reputation and the lives of his patients. The pharmacist serves as a frequently used source of valuable information on pharmaceutical and nutritional products; especially do physicians in the smaller towns depend heavily upon the pharmacist for this help.

Many a patient with a serious ailment of a parent with a sick child has consulted the physician earlier than would have otherwise been the case because of the wise advice of a pharmacist. Pharmacists are frequently in a position where they can do much to improve physician-patient relations, and in our experience, they seldom fail to avail themselves of the opportunity. As an example, pharmacists recently gave invaluable help to physicians in conducting a diabetes detection survey.

By working closely with the physician and by implementing and supplementing his efforts in the promotion of health and in the treatment of disease, the pharmacist has won a position of importance and respect second to none.

PHARMACISTS GROUP HOLDS PARLEY HERE

About 50 members of the Aberdeen District Pharmaceutical society met in the Mexican room of the Sherman hotel recently for the

regular monthly meeting.

Guest speaker was L. S. Flannedy, manager of the Twin City branch of a pharmaceutical supply company. Flannedy discussed salesmanship, stressing that it is "an art, science, profession, and a way of life."

Mrs. Frances Young, recently returned from an extended trip to Alaska, Hawaii, and the West coast, related interesting experiences during her tour. S. L. Mark spoke on his recent tour of the southern states, describing the drug business and drug stores in the cities he visited.

A nominating committee for new officers was named by A. O. Bittner, society president. Committee members are L. A. Daniels, chairman; Morris Jones, Gene Anderson, C. A. Dietz, Wallis Wimberly, and Patricia Procknow. The business meeting was conducted by Bittner.

The executive committee was authorized to select a date for the April meeting.

A dinner preceded the business meeting, Community singing was led by S. L. Mark. Gene Petrik, NSTC student, gave some impersonations and Eddie Olson sang several selections.

FAIR TRADE GUARDS YOUR DOLLARS

This is the title of a 16 page full color comic book for the education of your customers on the benefits which consumers derive from Fair Trade Laws. Nearly everyone likes to read comic books for a moment of relaxation. The story is simple and to the point. It illustrates how Fair Trade keeps prices down, protects against phony bargains, keeps their favorite brands on your shelves, protects the manufacturer's property rights, and gives a "fair break" to the retailer and the consumer. This book is published by the Bureau of Education on Fair Trade for the average customer who is likely to read it in this comic book form. The N.A.R.D. has requested this office to urge all South Dakota drug stores to order a supply of these books and distribute them to families in their trading area. Quantity prices are as follows: 100 to 500 at 3½ cents per copy, 500 or more at 3 cents per copy. Orders must be in multiples of 100. Mail your orders to—Bureau of Education on Fair Trade, 205 West Wacker Drive, Chicago 6, Illinois. Send check with order.

DRUGGISTS TO ARGUE FAIR TRADE CASE BEFORE U. S. SUPREME COURT

Permission has been granted the National Association of Retail Druggists and the Bureau of Education on Fair Trade to participate as friends of the court in the case involving Fair Trade laws now before the United States Supreme Court. The case will be argued during the week of April 9. At issue is the "non-signer" clause of the Louisiana Fair Trade law, which holds that a minimum resale price contract between a trademark owner and a distributor binds all distributors of a fair-traded brand in a state to maintain the fair trade price. Two liquor concerns sought to enjoin a New Orleans supermarket, which claimed it had not signed contracts with the firms, from violating its fair trade prices. The U. S. District and Circuit Courts in Louisiana upheld the liquor concerns in rulings on the issue. The appeal to the U. S. Supreme Court was joined by the Department of Justice, which asked the tribunal to determine whether the "non-signer" clause is exempted from the anti-trust laws by the Miller-Tydings Act. Practically all of the voluntary fair trade laws including South Dakota's will be affected by the ruling. In an unanimous decision handed down in 1936, the Supreme Court upheld the Illinois Fair Trade law, including the "non-signer" clause.

SIDNEY STORE MANAGER RECEIVES FIRST COPIES OF HIS RETAILING BOOK

Arthur Tremain, manager of the Montgomery Ward store in Sidney, has received the first copies of his book, *Successful Retailing*, from the publishers, Harper & Brothers, New York.

A handbook for store owners and managers, it covers the fundamental principals of retail store procedures — personnel work, general merchandising, displays, credit and collections, advertising and sales promotion, and the other principal elements involved.

Tremain writes out of 28 years' experience in store management, including service with Montgomery Ward and company, F. W. Woolworth company, and several independent stores, and extensive research into retailing and merchandising in the British isles and Canada.

In the book's preface, the author explains

that the work is intended to "offer helpful information to men and women today who are contemplating making retailing their life career."

In a brief review of the book, the publishers state that "it's coverage of every phase of retailing is encyclopedic. The book surveys the evolution of retailing methods in America and outlines current opportunities in the small-store field.

"The problems of store location and design, and the determination of basic policies, are analyzed in detail. In the area of personnel relations, separate chapters are devoted to executive leadership, hiring and placing employees, and training personnel.

"The book provides a concise analysis of salesmanship, and of advertising and promotion techniques. These are valuable chapters on what every store manager must know about inventory control, credit operation, record keeping, receiving and stocking merchandise, store maintenance, and specialized retail services. Included also is a special section on how to launch and operate a mail order business."

Three noted business executives have enthusiastically endorsed Tremain's book. R. E. Harrison, formerly president of Allied Stores, and vice president of Montgomery Ward, commented:

"The book is a comprehensive work. It contains a vast store of information which would make it a helpful handbook for the great majority of retailers, the so-called 'small business men,' who dominate the American retailing scene."

Daniel Bloomfield, manager of the Boston Retail Trade board, says of the book: "A comprehensive, authoritative, interesting and valuable guide to young men and women seeking a career in retailing, or considering the establishment of a business of their own. Those already in the field will find this book a refreshing summary of the principles underlying profitable store operation."

"Students and teachers will find Successful Retailing a carefully planned and detailed tour of the modern retailing scene led by an experienced and competent guide," was the endorsement of Frederick G. Atkinson, director of personnel and industrial relations of R. H. Macy and company.

(Continued from Page 108)

Braces, crutches, walkers, and ramps make walking possible, and especially designed automobiles make operation of such a vehicle practical for the handicapped.

All of the above activities are the responsibility of the physician who treats poliomyelitis patients in the convalescent stage, and his duties have not been properly performed until he is satisfied everything possible has been done to make the patient socially and economically independent and is sure that the patient is making the most of the muscle power that remains.

REFERENCES

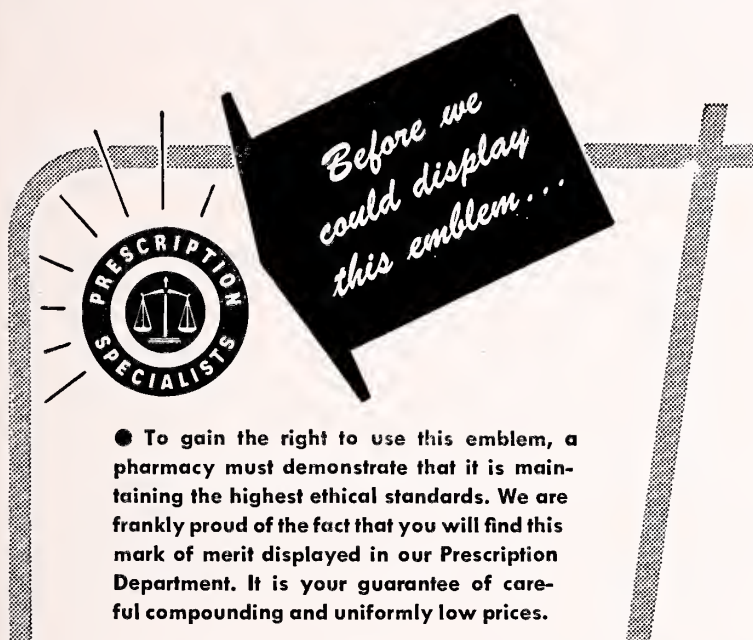
1. Poliomyelitis, Treatment in the Acute and Convalescent Stage. Gurewitsch, A. D., Hallock, H., Dugan, R. J. New York State Journal of Medicine, 48: 267, 1948.
2. Muscle Testing. Techniques of Manual Examination. Daniels, L., Williams, M., and Worthingham, C. Philadelphia, W. B. Saunders Company, 1946.
3. Preventive Orthopedic Procedures in Poliomyelitis. Pohl, J. F. Journal of Pediatrics, 33: 208, 1948.
4. The Natural Course of Poliomyelitis. Sherman, M. Journal of the American Medical Association, 125: 99, 1944.
5. Curare in the Treatment of Poliomyelitis. Richards, R. L., Elkins, E. C., and Corbin, K. B. Proceedings Staff Meeting Mayo Clinic, 22: 31, 1947.
6. Preliminary Report on the Treatment of Anterior Poliomyelitis with Exercise and Curare. Paul, W. D., Couch, O. A., Jr. Archives of Physical Medicine, 30: 277, 1949.
7. Muscle Behavior in Infantile Paralysis. Hipp, H. E. American Journal of Surgery, 53: 314, 1941.
8. The Response of the Quadriceps Femoris to Progressive Resistance Exercises in Poliomyelitis Patients. De Lorme, T. L., Schwab, R. S., Watkins, A. L. Journal of Bone and Joint Surgery, 30A: 834, 1948.
9. Functional Testing and Training in Physical Medicine. Bennett, R. L. Archives of Physical Medicine, 30: 263, 1949.

When
Your Patients
Ask You About
**HOSPITAL
INSURANCE**

REMEMBER

LEE McCAHREN
314-16 Paulton Bldg.
Sioux Falls, So. Dak.

ALL
PAUL REVERE
POLICIES ARE
**NON-CANCELLABLE
GUARANTEED RENEWABLE**



● To gain the right to use this emblem, a pharmacy must demonstrate that it is maintaining the highest ethical standards. We are frankly proud of the fact that you will find this mark of merit displayed in our Prescription Department. It is your guarantee of careful compounding and uniformly low prices.

"WELCOME"

three
registered
pharmacists
employed

BITTNER PHARMACY

**Plymouth
Clothing Co., Inc.**

212 S. Main

P & H Bootery

"The Family Shoe Store"

205 South Main



FRANCISCAN WARE
Aberdeen Crockery Store 511 S. Main

AUXILIARY ACTIVITIES



Mrs. Harold F. Wahlquist

DO PLAN TO ATTEND OUR FORTIETH ANNIVERSARY CELEBRATION AT THE STATE CONVENTION JUNE 3-6

By the time you are reading this, the convention will only be a week away! I sincerely hope that many of you are planning to attend our annual convention and to help us celebrate our Fortieth Anniversary. The Woman's Auxiliary to the South Dakota State Medical Association is the oldest, continuous auxiliary in the United States! We will honor our past presidents at a luncheon on Monday. We will have the regular business sessions with reports from the districts and from the state officers. We will have a School of Instruction for the new officers for the coming year.

Mrs. Harold F. Wahlquist of Minneapolis, our President-elect of the Woman's Auxiliary to the American Medical Association, will be our guest of honor this year. Mrs. Wahlquist will arrive late Sunday Afternoon in time to spend an informal evening with us and attend the Buffet Supper, which is being planned by the Aberdeen District Auxiliary. She will remain with us all day Monday and Tuesday forenoon, attending our sessions and advising us at our School of Instruction. Don't miss the opportunity to hear Mrs. Wahlquist, she will be our National President next year.

PRESIDENT VISITS ABERDEEN DISTRICT

Your president visited the Aberdeen District at the invitation of the committee on April 11th to help formulate plans for the social events at the annual convention. We enjoyed a wonderful steak dinner with the members of the District I Medical Society, then held our meeting in an adjoining room of the Sherman Hotel.

Plans were discussed and committees were appointed. There will be a buffet supper and entertainment on Sunday evening June 3rd. A luncheon honoring the past presidents and celebrating our fortieth anniversary will be held on Monday. Mrs. Wahlquist will be our guest speaker. Monday evening there is the annual banquet with the Members of the S. D. State Medical Association.

A Lunch at 12:00 on Tuesday will be given in honor of our guest, Mrs. Wahlquist and the state officers. This will follow the School of Instruction scheduled for the morning session on Tuesday.

The following committees were appointed and they will take care of all arrangements.

General Convention Chairman

Mrs. M. R. Gelber

Registration and Publicity

Mrs. R. Mayer

Mrs. M. R. Gelber

Hospitality and Transportation

Mrs. Rosenberger, Chairman

Mrs. P. Bunker

Mrs. E. A. Rudolph

Mrs. W. E. Martyn

Mrs. F. Cooley

Mrs. P. McCarthy

Mrs. T. P. Ranney

Mrs. E. A. Pittenger

Buffet Supper and Entertainment

Sunday night, June 3rd

Mrs. Frank Cooley, Chairman

Mrs. B. C. Murdy, Co-Chairman

Mrs. C. B. Murdy

Mrs. G. Steele

Mrs. A. Miller

Mrs. J. Calene

Luncheon—Monday

Mrs. E. A. Pittenger, Chairman

Mrs. R. Mayer, Co-Chr.

Mrs. C. L. Vogele

Mrs. P. McCarthy

Mrs. I. S. Schuckhardt

Mrs. T. P. Ranney

Brunch—Tuesday—12:00

Mrs. E. A. Rudolph, Chairman

Mrs. J. C. Brodine

Mrs. Paul Bunker

DISTRICT I REORGANIZED

As your president I am very happy to report that District I, better known as the Aberdeen District, has reorganized and returned to the "fold"! The new officers are:

President Mrs. A. J. Miller

Secretary-Treasurer Mrs. C. L. Vogele

SEE YOU IN ABERDEEN JUNE 3-4-5-6!

SEE YOUR OLD FRIENDS AND MEET SOME NEW ONES!

Mrs. A. P. Reding, State President

(Continued from Page 104)

many others must continue their great help and cooperation. All groups in the community must recognize the problems and help to provide the needed support and counsel.

The slogan for the handicapped is, "It is not what one has lost but what one has left that counts." I have indicated that the State Division of Vocational Rehabilitation extends to the handicapped persons in South Dakota a service which preserves "What they have left" and restore the physical, mental, social, vocational or economic ability in order that the handicapped individuals may become self-supporting. In short, Vocational Rehabilitation prepares them to become useful and employable citizens.

(Continued from Page 116)

Vogele and myself while **Dr. Van Heuvelen** and **Ben Diamond** represented the State Department.

Monday afternoon, still in Pierre, I met at length with **Governor Anderson** to discuss various medical member assignments to State Boards. The Governor is most cooperative with the medical profession and has a very

real interest in our activities.

From Pierre to Aberdeen on the ninth of April to see **Dr. Paul McCarthy**, general chairman for the local medical society on Annual Meeting plans.

Back to Sioux Falls on the tenth with no outside meetings until the 16th. That night I attended a meeting of four members of the steering committee for the Governor's Committee on Children and Youth to draw up concrete recommendations to the Governor.

The next day saw me in Parkston at a high school "Career Day" where I counselled a half dozen seniors on the healing arts and then spoke for half an hour to a combined group of 165. This talk was devoted to the evils of letting Uncle Sam do it for you, with stress on the undesireability of government health insurance.

Wednesday night I managed to take the wife to a dinner dance in Sioux Falls, but left at ten P. M. to drive to Rapid City to talk on legislation the next afternoon before the Black Hills District Medical Society. Visited with District President **A. A. Lampert, M.D.** before the meeting and discussed many facets of legislative activity with the membership at St. John's Hospital. Returned to Sioux Falls on the 20th and have been busy with more Annual Meeting activities.

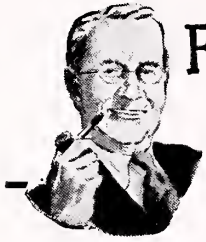
(Continued from Page 102)

BIBLIOGRAPHY

1. Abbe, R., Ann. Surg., 1897, 25:744.
2. Albarran, quoted by Papin, "Chirurgie du Rein," 1928. Paris, Gaston Doin et Cie., 2:319.
3. Bardeen, Am. J. Anat., 1901, 1:203.
4. Bardenheuer, quoted by Kelly, "Diseases of Kidneys, Ureters, and Bladder," 1922, D. Appleton & Co., 1:380.
5. Bazy, Louis, La Presse Medicale, 1914, 22:186.
6. Cabot, Hugh, J. Urol., 1925, 14:261.
7. Chevassu, quoted by Papin, "Chirurgie du Rein," 1928, Paris, Gaston Doin et Cie., 2:332.
8. Chute, R. and Souter, L., J. Urol., 1949, 61:688.
9. Costantini and Bernasconi, Presse med., 1930, 22:376.
10. Czerny, V., Centralbl. f. Chir., 1879, 6:737.
11. D'Antona, Compt. Rendu Cong. internat. de med., 1897, 5:302.
12. Duret, H., Jour. des Sciences med. de Lille, 1888, 11, pt 2:49.

(Continued on Next Page)

(Continued from Page 130)



From where I sit by Joe Marsh

Wrong Powder For Hunting

Seldom see Jackson the forest ranger—or ex-forest ranger—around these parts any more. He's retired now, on a pension.

Ran into him, though, over at Harpersbury, yesterday. Still hale and hearty—doesn't look half his age. He makes extra money guiding campers and hunting parties. Told me about something that happened to him on his last trip.

"We lost our way, back of Ten Mile River," he says. "And when I reached for my compass to check up, I found I'd brought the wife's compact by mistake! I used the sun to find the river, and we finally got out—but I sure felt like a real greenhorn . . ."

From where I sit, this shows how even the experts can get mixed-up at times. Take the way some "experts" would deny us the right to a glass of beer—or the way still others would like to tell a man how to practice his profession. I say they're experts only at minding somebody else's business!

Joe Marsh

Copyright, 1951, United States Brewers Foundation

13. Gregoire, R., quoted by Papin, "Chirurgie du Rein," 1928, Paris Gaston Doin et Cie., 2:331.
14. Hahn, E., Centralbl. f. Chir., 1881, 8:449.
15. Israel, Berl, klin. Wochenschr., 1883, 20:604.
16. Israel, quoted by Papin, "Chirurgie du Rein," 1928, Paris, Gaston Doin et Cie., 2:319.
17. Kelly, Howard, "Diseases of Kidneys, Ureters, and Bladder," New York, D. Appleton & Co., 1922, 1:385.
18. Konig, quoted by Tillmanns, "Lehrbuch der Chirurgie," 1898, translated from 4th Ed. by Tilton, New York, D. Appleton & Co., 3:273.
19. Kuster, E., Berl. Klin. Wochenschr., 1883, 20:-604.
20. Legneu and Fey, quoted by Papin, "Chirurgie du Rein," 1928, Paris, Gaston Doin et Cie., 2:335.
21. Mayo, W. J., Ann. Surg., 1912, 55:63.
22. Morris, H., "The Origin and Progress of Renal Surgery," Hunterian Lectures for 1898, London, Cassell & Co., 116.
23. O'Connor, V. J., J. Urol., 1949, 89:599.
24. Pean, M., quoted by Papin, "Chirurgie du Rein," 1928, Paris, Gaston Doin et Cie., 2:334.
25. Poncet, quoted by Kelly, "Diseases of Kidney, Ureters, and Bladder," 1922, New York, D. Appleton & Co., 1:380.
26. Robson, Mayo, Lancet, 1898, 1:1315.
27. Rosenstein, quoted by Papin, "Chirurgie du Rein," 1928, Paris, Gaston Doin et Cie., 2:335.
28. Simon, Gustav, "Chirurgie der Nieren," 1871, Erlangen, R. Enge, 1:23.
29. Tillmanns, H. "Lehrbuch der Chirurgie," 1898, translated from 4th Ed. by Tilton, New York, D. Appleton & Co., 3:271.
30. Von Bergmann, Berl. Klin. Wochenschr., 1883, 20:604.
31. Von Bergmann, quoted by Papin, "Chirurgie du Rein," 1928, Paris Gaston Doin et Cie., 2:319.

(Continued from Page 114)

8. Zapelloni, L. C.; Tumori, II, 526, 1912-1913.
9. Alessandri, R.; Surg. Gynec. Obstet., XLV, 35, 1927.
10. Gaylord, H. R.; J. Cancer Research, I, 197, 1916.
11. Riedel; Discussion — Verhandl. d. Deutschen Gesellsch. f. Chir., XXII Cong., 87, 1893.
12. Oderfeld, H., and Steinhaus, J.; Centralbl. f. Allg. Pathol. XII, 209, 1901. Centralbl. f. Allg., Pathol. XIV, 84, 1903.
13. Dickson, F. D., Diveley, R. L., and Helwig, F. C.; J. Bone and Joint Surgery, XXII, No. 1, p. 151-156, Jan. 1940.

The Office Diagnosis and Treatment of the Sterile Couple for the General Practitioner

C. A. Stern, M. D., Sioux Falls, S. D.

It is not possible to state the exact number of sterile matings in this country due to the fact that statistics on childless marriages do not distinguish between voluntary and involuntary sterility. Meaker estimates that somewhat over 12% of all married couples are involuntarily sterile. Of these couples who seek medical aid about 85% will be seen initially by the general practitioner. A large number of these people will then drift from doctor to doctor because pregnancy does not follow or, commonly, because they have not been given enough information to enable them to come to some intelligent solution of their problem.

Couples consulting a physician for the first time frequently have the idea that a quick inspection is all that is necessary to tell them if pregnancy is possible. They should be quickly disillusioned; several months may be required to complete studies, and a minimum of one year is frequently required before any definite decision can be reached regarding the final management of their problem. The procedures used in the field of sterility should briefly be explained together with the reasons for each step. Unless complete cooperation from both husband and wife is evident, it is best not to start studies. They may be told that, without knowing a thing about their individual case, about one third of all sterile couples undergoing study can expect a pregnancy within a year's time. They may also be told that if no pregnancy ensues a definite answer as to the cause of the sterility can usually be given, and if pregnancy is improbable or possible.

Couples who have been partially or completely studied elsewhere will know as a rule what sterility studies entail. Here it is usually best to start from scratch. Sperm studies, and tubal patency tests should always be repeated.

Before starting sterility studies the question will frequently come up as to the length of time a couple should have unprotected intercourse before they can be considered

sterile. In general this will be one year but each couple represents an individual problem. Previous pregnancies and the age of the female partner are the main considerations.

If one attempted to utilize all the various clinical and laboratory procedures that have been described for the diagnosis of the sterile couple none but the most hardy would ever complete their studies. Even with the accepted basic work up Frank in the Planned Parenthood Clinic in Chicago found that only 55% of his patients remained under observation for a period of one year. Both physicians and their patients become discouraged with the overelaborate rituals described in many of our texts. If four basic questions relative to each sterile couple can be answered using proven diagnostic procedures, the majority of patients can be given a definite answer to their problem. These questions are as follows:

1. Are the sperm normal?
2. Are the sperm reaching the uterus?
3. Are ova being produced?
4. Are the ova reaching the uterus?

ARE THE SPERM NORMAL?

Davis states that in one third of all sterile matings the husband is responsible and that in another one third he acts as a contributing factor. Williams puts male responsibility at 50%. According to Meaker these figures are too high; he believes that seldom is sterility due to any one factor in either of the partners, and he places male responsibility as the sole factor at 8%.

A complete sperm examination should be one of the first steps in the study of the sterile couple; it should be done before proceeding with endometrial biopsy or tubal patency tests in the female. A short history and physical examination of the male can usually be accomplished at the second visit. Emphasis is placed on past or present infection of the genital tract, hypogonadism, and congenital anomalies. The patient is given a clean wide mouth bottle and instructed to bring in a semen specimen within three hours

after intercourse and after a five day abstinence. Since even tap water will rapidly inactivate sperm no lubricants, jellies, or douches should be used. The semen is best preserved at room temperature but if more than three hours elapse before examination it should be kept in the ice box. If a fresh specimen is to be examined it is important to wait for about thirty minutes for mucolysis to occur otherwise an inaccurate count will result. A complete semen analysis includes volume, count in numbers per c/MM, motility, and morphology. The standard minimum values according to Simmons are as follows:

Volume: 2-4.5 cc.

Motility: 70-80% (with a time limit of six hours at 60-70°F.)

Count: 60,000,000 c/mm

Morphology: 70% of the sperm population.

In interpreting the results of semen studies quality is much more important than quantity. A low sperm count in the presence of a normal population has little effect on fertility unless the count falls below 40,000,000. The same may be said of poor motility; it is much more significant when associated with a pathological sperm population than when found alone. Although poor motility and low counts are commonly seen with an abnormal sperm picture it is not uncommon to find them unassociated. Simmons states that close to 25% of all male sterility will be missed if an abnormal sperm population is not recognized either because morphology studies are omitted or abnormal forms are not picked up by the laboratory worker.

Testicular biopsy may occasionally be indicated if the specimen shows a complete absence of sperm; this will distinguish between aspermogenesis and obstruction of the male duct system.

If a substandard specimen is obtained a repeat study is made in the matter of a few weeks. It is not infrequent for the count and motility to show a marked improvement, but a specimen that shows a high incidence of abnormal sperm will usually remain constant.

The treatment of the male showing a substandard sperm study is not specific. As a rule little can be done or hoped for in those showing a grossly defective sperm population because there is no known drug that will correct or promote spermatogenesis. The hormones are useless in this regard, although it

may be advisable to attempt to develop the sex characters in the hypogonadic male. It is also important to determine the status of the thyroid in these patients, and thyroid may be used even in the absence of any great deviation of the BMR from the normal range.

Subnormal counts associated with the presence of many pus cells in the semen are usually associated with a prostatitis or vesiculitis and offer a fair prognosis after treatment for these conditions.

It is common to see a subnormal sperm picture in the male who is under some physical or mental strain. Adequate rest, diet, and a general sense of well being are important general measures which should always be emphasized in any patient showing a substandard specimen. It is frequently advisable to give mild sedation to those patients who exhibit the symptoms of a tension state. Too great a frequency of intercourse must not be overlooked as a cause of temporary sterility and the patient should be instructed in the time and frequency of intercourse.

If after several months of treatment there has been no improvement in the sperm picture, a decision as to the final management of the case should be reached.

ARE THE SPERM REACHING THE UTERUS?

There is no single or simple procedure that will enable one to completely answer this question. From a practical standpoint a good pelvic examination done at the time of ovulation will give as much information as any other procedure. The anatomical anomalies such as a vagina cul de sac, and intact hymen, a closed cervical os, are uncommonly seen. Retrodisplacements and cervical infections are common enough, but the significance of these findings on the ability of the sperm to travel thru the cervix is not known.

The recent work of Shettles and Pommerenke have placed a great deal of emphasis on cyclic changes in the cervical mucus and variations in the ability of the sperm to penetrate the mucus at various times of menstrual cycle. The cervical mucus during ovulation normally becomes more copious (about ten times), transparent, and shows maximum flow elasticity. The ability of sperm to penetrate it is greatest at this time. If the patient is examined at the time of ovulation the physical character of the mucus is usually ap-

parent; if necessary a small amount may be withdrawn with a pipette. Little of practical significance is to be gained by the various in vitro mucus-sperm penetration tests. A thick tenacious mucus is usually obvious on examination.

The sperm responsible for the fertilization of the ovum are those which are ejaculated against the cervical os and almost immediately penetrate the cervical mucus. If the penis is abnormally short, the vagina deep or its walls redundant, the cervix "buried," or the sex technique faulty, post coital examination of the cervical mucus may reveal the absence of sperm despite a normal semen study. This constitutes a negative Sims-Hubner test; the test is indicated when history or examination leads one to suspect that the semen is not immediately contacting the cervical os. The Sims-Hubner test is not a substitute for complete sperm examination. The presence of 50 or more sperm per high power field in the mucus is considered satisfactory, although Rock states that 10 per high power field is enough to insure fertilization.

The treatment of male or female developmental anomalies are not within the scope of this paper. Cervicitis is best treated with local specific therapy of office cauterization. All operative cervical procedures are contra indicated. A thick cervical mucus seen at the time of ovulation will usually respond to low dosages of *ora* estrogen given during the first two weeks of the menstrual cycle. Faults of technique are corrected by education of the patient.

When it is impractical or impossible to correct developmental defects or when the Sims-Hubner test remains negative despite attempts at correction autoinsemination may be attempted. Insemination may also be attempted with a subnormal sperm count.

There are several methods used in the past in order to make the cervical os more accessible to the sperm whose rational are open to question. These include cervical dilation and correction of uncomplicated uterine displacements. The role of the precoital douche to maintain the activity or viability of the sperm is also questionable.

ARE OVA BEING PRODUCED?

Defects of ovulation occur in about 28% of all sterile women according to Stallworthy. The first clue to the absence of ovulation is

to be found in the menstrual history. An ovulatory cycles can be associated with any type of menstrual disturbance. However the presence of regular cyclic bleeding occurring at intervals of twenty eight plus or minus four days is good evidence that ovulation is occurring. In the 10% of sterile women that show cyclic anovulatory bleeding oligomenorrhea or periods of amenorrhea is the most common finding. About one third of these patients will give a history of normal menses.

The amenorrhic patient with the stigma of hypogonadism is easily recognized at the first examination. The underdeveloped sex characters play only a secondary role, since it is the absence of ovulation that makes these patients sterile.

There is no simple direct method of detecting ovulation. The basal temperature chart offers the most simple of the indirect methods of determining the approximate time of ovulation in the human. The patient should be instructed in the reading of the oral thermometer and the importance of taking the reading under the same conditions each day emphasized. The graph will also serve the purpose of enabling the patient to have intercourse at the most fruitful intervals. Ovulation usually occurs within four days of the initial temperature rise.

If the temperature graph can not be interpreted or confirmation of an anovulatory graph is desired a uterine biopsy which can be done in the office with a Randall or Novak curette is a simple procedure. The presence of a well developed secretory endometrium prior to the onset of menstruation is evidence that ovulation has occurred. Novak suggests that the biopsy be taken several days before the onset of bleeding since a better straining specimen is obtained at that time. The patient is told not to have intercourse during the preceeding midcycle to avoid interruption of a possible pregnancy.

The impression should not be gained that all sterile patients with menstrual disorders are sterile because they are not ovulating. The whole question of sterility and its relationship to the endocrines has yet to be answered. For want of a better heading a few of the diagnostic steps used in studying the endocrines in relation to sterility problems will be mentioned here.

Determination of the BMR is one of the

most important diagnostic steps to be taken in the study of the sterile couple. About one third of all sterile women will show a BMR of minus ten or less. Strangely enough most of these women ovulate. Any type of menstrual disorder can be associated with either a hyper or hypothyroidism. Novak states that in his experience menorrhagia is more common in the hypothyroid than in the hyperthyroid individual.

The use of time consuming blood or urinary hormonal studies in the diagnosis of sterility belongs in the experimental laboratory. In this category will fall blood gonatrophic hormone studies to distinguish between pituitary and ovarian type of hypogonadism. From a therapeutic standpoint the distinction is of no importance.

The treatment of the patient with anovulatory cycles or amenorrhea is largely the treatment of the endocrine factors responsible for the menstrual irregularities. There is no known drug or hormone that will induce ovulation regardless of the cause. The use of hormones in the treatment of sterility is experimental. Even though its mode of action remains unknown thyroid is a valuable drug for these patients, and dosage may be based on the level of the BMR. If the BMR fall within the normal range thyroid still may be given.

The patient with primary amenorrhea with evidences of hypogonadism presents a poor prognosis. Continued low dose oral estrogens may induce anovulatory bleeding and some development of the sex characters; usually this is the most that can be hoped for. An elaborate system of cyclic parental therapy with either pituitary or ovarian hormones is not indicated and accomplishes nothing.

If patients with secondary amenorrhea who do have ovulatory cycles there is little reason to do anything but reassure the patient that pregnancy is possible and instruct her in the timing of intercourse. If the amenorrhea is accompanied by anovulatory cyclic bleeding, the prognosis and treatment differs little from patients showing primary amenorrhea.

If anovulation is associated with menorrhagia or metrorrhagia and it has been established that such bleeding is on an endocrine basis, the prognosis is good. These patients will tend toward spontaneous correction, but cyclic hormone therapy with the idea of es-

tablishing "normal ovulatory cycles" may be tried.

The treatment of the amenorrhic sterile women would not be complete without mention of the work of Kaplan and Mazer on low dosage irradiation of the ovary or pituitary. These authors report a restoration of menstrual rhythm in 88% of their cases, and Kaplan reports that about one third of his amenorrhic sterile patients had successful pregnancies. These are excellent results but fear of the possible effect of radiation induced mutations and lack of sufficient confirmation by others in this field have kept irradiation of the endocrine glands from being an accepted procedure in the treatment of sterility.

Finally the not infrequent association of nutritional disorders especially obesity with anovulatory menstrual disorders make it desirable to treat obesity, malnourishment and anemia in any sterile woman.

ARE THE OVA REACHING THE UTERUS?

Occlusion of the Fallopian tubes is probably the most common cause of sterility in the female. The history will often give a clue to this condition. Significant points in the history are past abortions, febrile post partum courses, abdominal surgery, and pelvic inflammatory disease. Pelvic examination often will reveal the residue of an old pelvic inflammatory condition.

Uterosalingography offers the best method for the determination of tubal patency. Together with carbon dioxide insufflation it is both a diagnostic and therapeutic measure. About 10% of sterile women will become pregnant after this procedure. Radiopaque media offers several advantages over carbon dioxide; among them are:

1. The obstruction can be localized.
2. Unilateral occlusion can be seen.
3. Filling defects of the uterine cavity are outlined.
4. The diagnosis of tubal disease can often be confirmed.
5. Positional defects of the uterus can be confirmed.

The chief disadvantages are economic and the fact that occasionally one will cause a peritonitis. Stallworthy in the study of 1,000 cases of sterility found the incidence of tubal occlusion using gas to be from 25-50% while his incidence with oil was 21.6%.

Neither group was given spasmolytics.

An elaborate apparatus is unnecessary. If a fluoroscope is available, the direct injection of iodized oil thru the Keyes-Utzelmann cannula is ideal. If none is available or if the patient is unable to return for the routine 24 hour film Huggins' modification of the Colvin cannula can be used, since only one or two films are necessary to reveal a good peritoneal spill. This cannula is a screw type which turns into the internal os and retains the injected oil in the uterine cavity by means of a one way flow valve. After about twenty minutes following injection during which the patient may be ambulatory tubal peristalsis will give a sufficient spill to be seen on the x-ray plate. This method does not outline the tubal lumen as well as oil injected under fluoroscopic control.

Unless preliminary medication with atropine or with an atropine-barbiturate combination is used, the incidence of tubal occlusion will be much higher than that shown by subsequent patency tests. This is particularly true of gas insufflation. Sharman states that only 32% of cases showing non-patency on a single test have occluded tubes. Tubal spasm then will account for the majority of tubal occlusions found in any single test.

Frequently the salpingogram will show such advanced tubal involvement that it is obvious that further patency tests done from a therapeutic standpoint will accomplish nothing. If repeated test are indicated as in most cases both from a therapeutic standpoint and to rule out tubal spasm, carbon dioxide insufflation using pressures to 200mm of mercury with preliminary medication should be used.

**Continental Pathfinder
Vertical Fluoroscope
For Sale
1950 Model**

Very Reasonable

O. W. Katz, M.D.—Aberdeen, S. D.



**From where I sit
by Joe Marsh**

The Cow That Can't "Run Dry"

Sandy Johnson showed me his Jersey cows last week. It was a warm day and they were all under the trees near a watering trough.

And darned if one cow wasn't pumping water into the trough! It's a fact—she'd raise the pump handle with her nose, and use her throat to push it down again.

"That's Mabel," Sandy explained. "Sometimes they drink that trough dry, and she's learned how to fill it again. But she doesn't know her own strength—turns the place into a swamp if we don't watch her."

From where I sit, Mabel isn't the only one who doesn't know where to stop. For instance, people who carry their ideas too far—like those who would tell a man how to practice his profession . . . like those who would tell their neighbors what beverage to choose. I prefer a glass of beer with my meals. I know that a lot of other people prefer milk. But nobody ought to insist on "herding" others to his way of thinking.

Joe Marsh

Newer Therapeutic Agents

Edgar Parry, Instructor in Pharmacy

South Dakota State College

The Pituitary and its products:

This article is taken from a talk, titled "Recent Advances in Drug Therapy," which I presented at the Pharmaceutical Institute this year. I have divided it into two parts; this part I have called, The Pituitary and its products. The second part will appear next month and will deal with the Physiological activity of ACTH and Cortisone.

Of the many drugs which have found their way to the stock shelves of hospital and drug store pharmacies in the past year, the most notable are ACTH and Cortisone. The mystery surrounding their pharmacology, along with their heretofore unsuccessful field of therapy, have made them the most dramatic drug discoveries since the advent of antibiotics. They have affected new cures and have shown themselves beneficial in many other disease conditions, yet it is possible that they may weaken body defenses to still other diseases.

Their action and use is empiric. We are finding more evidences of physiological changes produced by these drugs with continued administration; however, the direct mode of action in almost all cases is theoretical at best. A minimum is known about the two hormones themselves, and until the turn of the twentieth century even less was known about the glands which produce them — the anterior lobe of the pituitary and the adrenal cortex. While we have added a considerable amount to our knowledge of these glands in the last ten years, we have really only served to awaken ourselves to further possibilities in therapeutics, new problems in physiology, and new theories in pathology.

Many questions, as yet unanswered, present themselves. What is the relationship between the collagen diseases such as rheumatoid arthritis and Cortisone? Since the adrenal glands evidently function normally in persons inflicted with these diseases, what bodily

function, which can be corrected by administration of extra Cortisone, has failed? What are the long term advantages of giving either ACTH or Cortisone over the other? Why should Cortisone be so active in healing acute ocular lesions, yet show evidence of inhibiting epidermal regeneration in animals?

Furthermore, it has been shown by experiment that hamsters and Swiss mice have a relatively high immunity to the polio virus and have a low mortality rate among those succumbing to the virus following inoculation. However, when dilute doses of Cortisone are administered along with the inoculation, all of the lab animals contract the disease and suffer one hundred percent mortality. When ACTH was substituted for Cortisone in this experiment, it failed to raise the percent of sick animals, or the mortality rate above that of hamsters which received no ACTH. Evidently some hormone from the adrenal cortex, produced by stimulation of ACTH reverses the effect of Cortisone.

This leads to several natural questions. To what extent do the results of this experiment apply to human polio cases? What is the neutralizing factor and would it counteract polio? To what extent do Cortisone and other body hormones enhance pathologic conditions?

The answer to most of these questions will come through experimentation and use, and through the results we will understand the pituitary and adrenal glands much better. The boundary of usefulness of these two powerful hormones is limited by their physiological activity when produced naturally in a normal body.

The anterior lobe of the pituitary acts as a primer or generator to the body. It has been likened to a Field General which governs vital processes within the body through private messengers. At the present time, six messengers or hormones are recognized as emanating from it. All except one, are tropic

hormones — chemicals which are aimed at specific glands to stimulate them in the production of their secondary hormones. It is these that carry on the vital processes.

The pituitary seems to be automatic in nature, regulated somewhat by the hypothalamus of the brain, and to some extent by the secondary hormones which it causes to be produced. Higher brain centers may influence it, and under stress conditions of hunger, fear, cold, fatigue, etc., it is thought the adrenalin from the adrenal medulla stimulates it. The six tropic hormones resulting from this stimulation can be divided into two groups: gonadotropic and metabolic.

In the gonadotropic group, the Follicle Stimulating hormone is directed at the ovary where it stimulates the growth of a follicle to maturity and an accompanying production of estrogen. In the male it is directed to the seminiferous tubules and there stimulates production of sperm and an Androgenic hormone. The Interstitial or Luteal tropic hormone stimulates the Corpus Luteum in the production of progesterone, and in men it stimulates the testes in the production of testosterone. The third gonadotropic hormone is the Lactating hormone which activates the milk glands after childbirth.

The metabolic group includes the Growth hormone, the only pituitary hormone not aimed at a gland or organ, but rather at the cells themselves. It causes the nucleus and protoplasm of the cells to divide and grow. The Thyrotropic hormone stimulates the thyroid in production of its hormone thyroxin. The last and most recently discovered tropic hormone is ACTH, the adrenal cortex tropic hormone or Adrenocorticotrophic hormone. ACTH stimulates the production of the entire spectrum of hormones of the adrenal cortex which includes Cortisone.

The metabolic nature of ACTH was definitely established in lab experiments on rats. Rats which had their pituitaries removed were fed Growth hormone and attained a size six times that of the normal rat. Thyro-

tropic hormone was shown to reinforce the growth hormone, but ACTH counteracted its effect and even retarded growth in normal rats. Thus the pituitary provides the growth stimulator with an accelerator and a brake.

Incidentally, there is a good chance that there are other hormones produced by the pituitary. It has been noted that many normal rats develop pituitary tumors when fed Growth hormone over a period of eight to ten weeks. However, none of the rats which have had their pituitaries removed have developed tumors. This evidence seems to point at a cancer producing factor in the pituitary. It would have to vary only a little from the Growth hormone.

The adrenal cortex produces in total some twenty substances. They are mainly concerned with three basic duties: maintaining sex balance; metabolism, mainly carbohydrate metabolism; and the regulation of the electrolyte system of the body, maintaining blood volume, etc. Cortisone comes under the metabolic category, yet overlaps the others. The full extent of its activity is not yet known. We have only the evidence from the results of its administration from which to judge its full effects, and as yet the results are too irregular to be conclusive. They have been termed "effects" rather than "actions," and since ACTH depends upon the Cortisone it stimulates for its effect, their uses and side effects are mainly those of Cortisone. The difference seems to lie in degree of intensity since ACTH stimulates the production of some twenty other hormones along with Cortisone and these tend to modify the action of Cortisone somewhat.

(to be concluded)

The following is a partial bibliography:

1. Medicine of the Year, third issue, 1951, J. B. Lippincott Co. pg. 36-50.
2. American Professional Pharmacist 17:247, March 1951.
3. Habif, D. V., Hare, C. C., and Galser, G. H.: Perforated duodenal ulcer after ACTH therapy, J.A.M.A. 144:996, 1950.
4. Cortisone, Acetate, Merck Pub. 1951.
5. The Pituitary, LuChang, H., Scientific American, November 1950.



New 2-Way Aid in ACNE

Now hide and treat acne blemishes simultaneously with new AR-EX R.M.S. Lotion. Complexion tinted. Contains resorcinol monoacetate and sulphur in gentle AR-EX Foundation Lotion. Non-astringent.



AR-EX
R.M.S.
Lotion

AR-EX COSMETICS, INC., 1036 W. Van Buren St., Chicago 7, Ill.

Send for Free Sample.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Some Considerations on the Use of Professional Social Case Work by the Physician in Problems Involving the Welfare of Children

by Rev. Benjamin A. Gjenvick, M.S.W.

There is a growing recognition in the professions today of teamwork as an important means of providing more effective services to patients and clients. The professions of medicine, law, nursing, the ministry, and social work are discovering new ways of, and new values in, working together. At the same time, new specialties are developing to carry responsibilities formerly handled by others. The existence of specializations imposes on all professions the need for clear understanding of each other's roles and capabilities, so that the individual seeking the help of one may also have the help that the others can give.

The growth of social work is one example of the recent development of a profession with its own competence peculiar to itself. Social work has come to carry responsibilities once shared chiefly by physicians,¹ lawyers, ministers, and "Lady Bountifuls." It has borrowed heavily from other professions and from the research findings of psychiatry, internal medicine, obstetrics, pediatrics, psychology, and sociology. In turn, from its own practice and research, a body of knowledge and skill has been built up.

In order to understand how the professions

of medicine and social work can better help their mutual patients and clients, it is necessary for the physician to be familiar with what services the social worker is qualified to offer, and how he has developed competence in these areas. The development of professional social work has occurred in this century, largely in the past 20 to 30 year. It is now in the position of some of the newer medical specialties, with a continuing need to interpret itself. Professional social work has, in addition, the handicap of being practised under the aegis of agencies, many of which have in the past and still do employ so-called "social workers," who lack professional educational qualifications and competence. This is due in part to professional personnel shortages, and in part to the great demand for social work services. Many social agencies derive their chief support from philanthropic sources, and consequently social work has often been disadvantageously identified with "charity." On the contrary, social work today offers services which are used by persons regardless of economic need. Adoption is only one example.

Professional social work education is provided on the graduate level. Entrance requirements for schools of social work accredited by the American Association of Schools of Social Work include a bachelor's degree from an accredited college, and a sequence of undergraduate studies in the biological and social sciences. The two year professional course leads to a Master of Social Work degree, or to one with an equivalent title. Many social workers now take a third year of advanced training following a number of years of experience in the field. The doctorate program, involving a fourth year, is attracting an increasingly growing group of social workers.

The academic content of professional social work education is designed to provide the

* Rev. Gjenvick is the Executive Director of the Lutheran Welfare Society of South Dakota. He received his education at Augsburg College, Minneapolis, B.A. 1943; at Augsburg Seminary, Minneapolis, C.T. 1946; and at the University of Pittsburgh School of Social Work, M.S.W. 1948; and in the University of Minnesota Graduate School.

1. "Social agencies . . . that have studied the problem (of adoption) certainly are far better equipped to make decisions in this matter than physicians, who are ignorant of the possible consequences. In the final analysis, the physician is a highly trained technician whose education in welfare work has been neglected, while welfare agencies have improved to such an extent that the states of our Union have seen fit to grant them special privileges in the handling of children for adoption." Weisman, Abner I., M.D. "The Role of the Physician in Child Adoption," *American Journal of Obstetrics and Gynecology*, 47:868-869, June, 1944.

student with a working understanding of human behavior, its development, meaning, and abnormalities. The physical, psychological, and emotional development of the human being is presented by medical specialists, psychologists, and other social scientists. Appropriate clinical observations of individuals at various stages of development from the neonate to the aged are provided. The nature of physical and mental illnesses and their effects on personality and behavior are studied in some detail. Since cultural and sociological factors influence human behavior, the findings of anthropologists and sociologists are utilized to provide the student with an intelligent and useful frame-of-reference for evaluating these factors as they appear in the problems of his clients. The social work student learns of the historical development of his profession, and the history and organization of social welfare activities. He learns, too, about the function of other professions, and the relation of social work to them.

The distinctive application of knowledge, techniques, and skills which is in essence social work is gradually learned in the classroom and in the agency clinical setting. This learning is achieved largely from a study of record material, both that of others and of the student himself. Assuming a case work setting,² the record presents the interview process through which the social worker enabled the client to explore his problem and his feelings surrounding it, and the decisions and solutions that the client achieved through using the social worker.

Concurrent with his classroom studies, the social work student is placed in a community social agency. Carefully selected cases, again assuming a case work setting, are assigned to him. He records his interviews in detail to show the client's and his own participation. Together with his clinical supervisor, he analyzes his functioning, seeking to understand his client, the interviewing methods he employed, and his own feelings and motivations as the helping person. As the student

2. Social workers practise in a number of settings: as case workers, helping individuals with problems to find solutions and to put them into effect; as group workers, enabling the individual members of the group to participate actively and responsibly, and the group-as-a-whole to reach decisions and to carry them out; as community organizers, helping community groups to reach their common goals; and as social research specialists.

acquires insight into himself, he also develops conscious control and discipline of his own responses. He learns to use himself in a way that is helpful to his client. Thus, the social work student changes from a person, who merely likes people and wants to do them good, into a professional practitioner.

Underlying professional social case work practice in a democratic society at the present time are a number of basic philosophical assumptions and practical principles, which have grown out of years of experience in the social case work field:

1. Every individual who comes for help has at least some strength of personality, which he can utilize in the solution of his problem. The very fact that he seeks help to change his situation is evidence of this.
2. Every individual has capacities, however limited, and the right to make his own decisions.
3. The truth is the only basis on which a realistic solution to a problem can be built. Consequently, a social worker must always be honest with his clients.
4. It is essential to discover where the individual is, in relation to solving his problem, and to begin working with him at that point.
5. An individual is best helped when he is stimulated and assisted to define his own problem for himself, and the solutions possible for him.
6. Every individual has his own rate of progress in solving his problem, a rate which the social worker must accept in order to help effectively.
7. Help is most effective when it rests on a non-judgemental attitude toward the individual, and on a warm acceptance of him as a worthy person.
8. Each individual is unique, and cannot be helped exactly like any other.

In the professional social worker the physician will find a disciplined practitioner, who can serve his patients by helping them to cope more effectively with problems, arising in their social relationship, which fall beyond the scope of the physician's practice and competence. The practice of child welfare agen-

cies, such as the one with which I am associated, illustrates how physicians and social workers cooperate in the best interests of the patient. This practice suggests, too, the beneficial possibilities of wider use of social workers and social agencies by physicians.

Most child welfare agencies, including my own, offer services to unmarried mothers. Residential care in maternity homes, or in family boarding or work homes, selected and supervised by a social worker, is offered. The unmarried mother selects her physician from a group of practitioners, associated with the agency, who accept obstetrical patients. Some unmarried mothers remain in their own families or relatives' homes, and use community hospital and medical resources. Whatever arrangements the unmarried mother decides to make for her physical care, agencies offer her professional social work services in the environment she selects.

Pregnancy outside of marriage is a symptom of a greater or lesser degree of emotional and social immaturity, a failure to find a satisfying life within the framework of community mores, values, and standards. Recognizing the degree of immaturity which may exist, the social worker uses his knowledge and skill to help the unmarried mother handle her situation as responsibly as she can. The social worker is not a psychiatrist, and hence makes no attempt to deal with the unconscious motivations and causes of the unmarried mother's problem. He does bring to bear a general understanding of the environmental, emotional, and social factors involved in unmarried parenthood, raises questions, suggests possibilities, summarizes the discussion, and focuses the interview on the immediate problems and issues faced by the unmarried mother: How is this experience affecting her relationship to her own family and friends? What about her relationship to the father of her child? How does she plan to pay the bills incidental to her pregnancy? How will she care for her child? No effort is made to manipulate or coerce the client into accepting a decision or course of action considered desirable by the social worker, but not by the client. The social worker's purpose is to enable the client to find her own solutions and to carry them out. To do this the social worker must be continually aware of his own feelings and objectives, so that she

can control them consciously. Without this self-awareness, the social worker might manipulate a client's destiny — manipulation which could later backfire disastrously for the mother, her child, and, possibly, an adoptive couple. The client's experience of developing responsible courses of action for herself, with the social worker's help, has as one of its most significant by-products, increased emotional maturity.

Frequently, an unmarried mother is poorly informed concerning the basic facts of the physiological aspects of pregnancy and delivery. The social worker explores the unmarried mother's knowledge in this area, referring her to the physician for answers to questions regarding her own physical condition, and also, in consultation with him, interpreting his statements and explanations to the client. The unmarried mother is often overwhelmed by feelings of guilt, shame, hostility, and fear. These feelings stand in the way of her making constructive plans for herself and her child. The social worker encourages the client to recognize her feelings, and to talk about them as factors involved in the concrete decisions to be made. With this help, an especially fearful and ashamed unmarried mother may be enabled to see a physician early in her pregnancy, and to face delivery calmly and with understanding.

The social worker also stands as a buffer between the client and any persons seeking to influence her unduly, such as members of her family, friends, and persons wanting to place or adopt her baby. From the help of a social worker the unmarried mother secures a realization that the decisions are hers to make, with the wishes and opinions of those close to her as factors she must consider. The social worker also acts as a resource of information concerning the unmarried mother's legal rights.

If the unmarried mother decides it is in her own and the child's best interests that he be placed in an adoptive home, the social worker is able to offer her the placement services of the agency. Should the unmarried mother seem unsure of her decision to place her baby for adoption, the agency can offer her the chance to place him temporarily in a boarding home, so that she can learn what supporting him would be like. Adoptive placement in a modern agency is the respon-

sibility primarily of professional social workers. The adoption process involves the social worker and the physician in a continuing working relationship.

Most couples who seek adoption as a way of having a family do so because of their inability to have children of their own. Many sterile couples are referred to agencies by physicians. In other cases, however, couples have often not fully explored the possibilities of having children of their own. In these instances, the social worker refers the couple to their family physician for a sterility study, which either he or a gynecologist makes. Many couples, learning from the social worker about the medical help they might receive to increase fertility, have gone on to have children of their own with medical assistance. A statement from a physician giving the reason for sterility is usually required as a part of the application procedure.

It is important to realize that many more couples seek to adopt infants than there are infants available for adoption. From the viewpoint of the child, this is a fortunate situation. A high degree of selectivity can be exercised in choosing the home most suited to him. Throughout the placement process, the social worker's primary concern is to secure the best possible home for each child, and not to secure a baby for every childless couple. This is one of the chief differences between an agency placement and one arranged by individuals in the community whose first interest is likely to be securing a child for a particular couple.

Utilizing his skill and understanding, the social worker explores adoption with the couple in a series of office interviews and home visits, including one or more interviews with the husband and wife separately. They are helped to examine their reasons for wanting to adopt a child which may range from a perfectly healthy desire for parenthood to the need to be like other people without any real liking for children, the wish to duplicate exactly a child who has died, or an effort to mend a failing, unhappy marriage. In such cases, the social worker must help the couple to accept their rejection as adoptive parents, for no child could possibly meet the couple's needs.

The social worker seeks answers to two questions with the couple in his interviews

with them: Will they provide a satisfactory home for a child? What sort of child would best fit them? Much of his work with a couple goes toward helping them become better adoptive parents than they would otherwise be. For example, how a couple is able to come to terms with their inability to have children, and whether they come to terms with it at all, is related to their ability to love an adopted child. The sterile husband or wife may suffer from self-blame, or the fertile partner may secretly resent the inability of the spouse to make possible a family of their own, because of the high value placed upon virility in our society. The social worker seeks to help them handle their feelings in a mature, realistic manner. He also tries to help them to feel comfortable with the implications of adoption, so that they will be able to talk with their adopted child, their relatives, and their friends about the adoption and about the child's natural parents. The adoptive parents, properly prepared for the experience of parenthood, will not need to pretend to themselves or to the child that he is their natural child. Such pretense has led to disillusionment, distrust, and complete loss of faith when children have learned the truth, as they inevitably have. At the same time, the adoptive parents will enjoy foster parenthood for what it is, a highly satisfying and rich experience.

In the selection of an adoptive home for a child, the social worker utilizes information gained from the child's own parents concerning his background, medical information about the mother's pregnancy and delivery, observations of the child's appearance, development, and responses by the obstetrician, pediatrician, boarding mother caring for the child prior to placement, and the social worker serving the child. Basic information about the child, his heredity, and his background is shared with the prospective adoptive parents. Before and after seeing and getting acquainted with the child, the couple decide whether or not they want him. It sometimes happens that a couple will reject a child selected for them. When this occurs, the reasons for rejection are carefully examined, and the couple and social worker decide whether to go on with another placement. In most instances, another placement

(Continued on Page 143)

"Dakota GP"

Introductory Note:

At the Huron meeting, April 22, 1951, of the S. D. Chapter of the Academy of General Practice, we discussed the advisability of getting together some of the better stories of the hardships, life and experiences of general practitioners in South Dakota.

The horse and buggy age is past. When enclosed automobiles came to stay, the maximum hardship of winter and night driving was past. However, the stories that live on, recounted from the horse and buggy era, and the time when Lizzie was no lady, bring a nostalgia to those who saw medicine practiced against all odds. We believe many of these stories have great interest to all physicians and possibly more so to the reading public. The old beloved friend and family confessor, the country doctor, is leaving the prairie succeeded by a better dressed and better educated successor. That is as it should be. That's progress.

As we watch the horse and buggy physician shuffle towards oblivion, our hearts are filled with admiration, love and some pity. He had such a big heart. He loved his people in spite of their frailties and cared for them often beyond his physical endurance. He kept their secrets and always gave them honest advice. Some of his stories are worth retelling again and again. To this end, let them be told now, before the beloved Horse and Buggy Doctor and his memories leave forever.

The above was my suggestion at the Huron meeting. When I asked our secretary John Foster if he would compile these stories, he replied: "You are the one who stuck his neck out, doc, so you may write the first story." Well . . . I guess he is right. Here is the first story. It is perfectly true in time, place and names.

J. A. Kittelson, M.D.
Sioux Falls, S. D.

I

LOST IN A BLIZZARD

Every G.P. who has seen practice in the Dakotas has experienced a blizzard.

Mine happened in early January of 1924. The fall and early winter had been unusually mild in North Dakota. Christmas Day was so clear and warm that as we played golf in the afternoon, we rashly compared our state

with California, and a general satisfaction was expressed with the mild winter. This northern state yielded such satisfying conditions of living that its inhabitants found many reasons for staying and were ever magnifying the good and bountiful natural gifts of the country. There was the good and healthful air, the wide visibility, cheap local lignite coal and cheap farm land. And when an occasional wet year came along, everyone bought a new Buick!

But how rapidly the picture changed on New Years Day. An east wind had been moving an ocean of humid air into the area. Then the wind changed to the northwest and really started to blow. Big wet snow flakes started falling and it rapidly started to get colder. The snow flakes became smaller and streaked along before the storm. It was an old-fashioned blizzard and getting colder every minute. About nine o'clock in the evening, the telephone summoned me to the Osterberg farm, about half way between Tolley and Mohall, a distance of fifteen miles. Mrs. Osterberg was about to have her baby. Automobile travel was out of the question, so the drive had to be made in a covered sleigh. Arrangements had already been made with Carl Ostrum; he was to drive me during the winter months. He had some fast Indian ponies and an enclosed sleigh, adorned with two automobile gas head lights. It was wind proof and supplied with extra blankets. We put on our sheepskins and started. How those ponies hated to face that wind. They continually wanted to turn away from the storm but we managed to hold them to it. We could see very little but through sheer instinct could feel the road. The reflected glare of the headlights on the telephone wires beside the road helped us and gave us confidence that we were going right. It was the first sleigh trip of the winter and the miles seemed endless. We were just crawling along. Having full confidence in my driver and his ponies, I decided on a short nap. My eyes closed for just a moment.

I woke with a start. Was it possible the wind had changed? The horses were no longer plodding into a head wind but the wind now struck my side of the sleigh. A glance along the side of the road where the telephone line should be made little shivers run up and down my neck. No telephone line.

The horses had turned away from the wind and were headed at right angles to the direction where we should be going. By this time the snow was deep and landmarks were obliterated. We were not even certain that we were on a road. After a brief conference we decided to give the horses their head and see if their instinct wouldn't be better than ours. We were really worried, since the storm was getting worse and worse. Why did women have to have their babies on the worst possible nights? Was it always thus — as soon as the weather became real dirty, the doctor could expect two or three obstetrical calls?

Suddenly the horses slowed, then came to a stop. No urging could make them move. The driver waded ahead to investigate and came floundering back to report that we seemed to be up against the side of a house. We left the horses in the lee of the house and circled around looking for a door. Knocking brought no response, so we opened the door and stepped inside. Blessed heat hit us broadside. We had blundered onto a country school house . . . a one room affair heated by a one flue furnace. Whoever had stoked that furnace must have been looking for a blizzard . . . it was glowing red at the bottom of the flue. We were soon warm and comfortable. Then the thought returned . . . we must get to Mrs. Osterberg, if at all possible. But where were we? The school house had a telephone but we knew no numbers and central was closed. This was a country line where one called various people by ringing certain sequences of short and long rings. The only "ring" I knew was my own in town, so I started ringing that, hoping that someone on the line would get up and answer out of curiosity if nothing else. Party lines being what they are, we got an answer almost at once. It was Mr. Osterberg himself. He knew exactly where we were and agreed to come and take us to his place.

It was with considerable relief that we waited for Osterberg. Driven by paternal urgency, he was at the school house in a very short time. I rode with Osterberg and my driver followed with his team.

The Osterberg kitchen was bustling with activity . . . water was boiling . . . lights were on all over the house . . . the neighbor woman helper was there . . . coffee was hot . . . bed

was changed . . . kids were dressing all over the place. Everything was bustling except Mrs. Osterberg. She felt fine. Her pains had stopped and she was just as comfortable as could be. Outwardly she was contrite about the whole affair. However, traces of a smirk flitted across her face which she couldn't quite conceal. My impression was that she was really enjoying herself. Apparently, this was a good one on Doc.

We sat down and had a fine breakfast and a good visit. The blizzard died out during the forenoon and we returned to Tolley without any trouble. In daylight, we didn't have to follow any particular road . . . we cut across the fields of white without mishap.

And Mrs. Osterberg? — she called again three week later. This time we sped across well packed highways. This time, there was no difficulty. This time, we were too late. The baby, a daughter, unpredictable as all womankind, had had the last laugh.

(Continued from Page 141)

goes smoothly for the couple.

During the period after placement and prior to legal adoption, the social worker visits the adoptive home, assisting the parents with information about the child, and with counsel in fulfilling their new role successfully.

In summary, these are the salient factors in effecting a good working relationship between social worker and physician:

1. Professional social case workers possess a body of knowledge and skill which they use in a disciplined manner to help clients with problems arising in their social relationships.

2. Physicians can help those of their patients who could profitably use the services of a social case worker by referring them to licensed social agencies which make professional social work services available.

3. The social worker is prepared to make appropriate use of the physician for referral and consultation purposes.

4. The physician can work to strengthen and create agencies offering professional social work services.



PRESIDENT'S PAGE

L. J. Pankow, M.D.

June Message

What would you do, Doctor, if your office nurse quit and you were unable to replace her? There is no greater threat to the practice of Modern Medicine than the astounding decrease in the number of applicants for nurse's training. This decrease is a horrifying fact. One University School of Nursing this Spring graduated only SIX nurses. Last year at another School of Nursing there were over a hundred freshmen. This year there are but twelve.

Whatever the cause of this decrease may be, the remedy had better be found and applied by us as a profession or we are going to find an unpleasant and unwanted change in our methods of practice. Let's not kid ourselves about it, either. We have changed from a home to a hospital practice since the last war. The necessity of that era has become the accepted of today. We used to have a girl in the office chiefly to answer the phone while we were out. Today we find that a graduate nurse makes it possible for us to take care of many more patients by her efficient administration of medications and treatments, while we are examining and diagnosing new patients. Just what **would** you do if you could not get another nurse in your office when this one quits? And what are you going to do when your hospital is unable to remain efficiently open because there are not enough nurses to keep it going?

This MAY not be your problem, Doctors, but you had better make it so. These comments and questions are not fanciful flights of the imagination. In view of the drop of enrollment in nurses' training, the problem is acute. We must, as individuals in our profession, spread the gospel of the advantages of a nurses training to our young women and their parents.

The advantages are many. Here is a higher education at a minimal cost to qualified girls. Scholarships are open for young women without means who are otherwise acceptable. It should not be necessary to call any Doctor's attention to the advantages of a Nurses Education. It assures excellent earning ability for a single girl. It is a wonderful preparation for efficiency in home management and family care. It is refined work for a young wife to help out while her husband is advancing to a position of financial prominence in the world. It is excellent insurance against want and dependency for a widow.

Wherever you live, Doctor, there must be some qualified young women who cannot afford college who are fitted for higher education. Some of these would welcome a chance to get nurses training if they but knew of it. You are remiss if you do not tell your young women about these advantages that are open to them. By helping these girls to a good professional education we are also helping ourselves against the threat against our present methods of Medical Practice, in the hospital and in our offices.

Better think this over, Doctors, and if you can encourage some young women to get into nurses training you will be helping them for their own betterment, doing the world a favor by providing educated and efficient women to care for their homes and families, and above all, providing means for you to continue the efficient practice of your Art as you have become accustomed.

GET BUSY AND RECRUIT SOME STUDENT NURSES FOR OUR HOSPITALS.

EDITORIAL PAGE

WAGES AND PRICES AND MORE CONTROLS

Thursday evening, May 17, a group of representatives of the various organizations interested in meat production met in Huron to discuss wage and price controls. Out of this meeting comes the idea for this editorial.

While not specifically interested in wages and prices, the medical profession is interested in what controls the government slaps on to limit freedoms of individuals. The consensus of opinion amongst the meat growers, feeders, packers, etc. was that price controls, while they might lower costs of meat to the housewife temporarily, would in the long run drive meat off the market in a few years. Bringing beef to the buyers table is not an overnight process and if the law of supply and demand is not allowed to operate, producers all along the line will cut down production. Then, when price controls are removed — instead of an increase in production, there will just be an increase in price as buyers compete for the scarce commodity.

Wage and price controls are wartime necessities. We must either have full wartime controls or a free economy. When any administration insists upon **some** controls in the guise of war emergency it is the same process they are attempting when they would socialize medicine to "help in the war effort."

Cool judgement on the part of every citizen and lawmaker is a must when the bureaucrats try to sell controls under the guise of preparedness.

We must be ready to call the turn on our representatives in Washington when bills come up that would deprive us of our freedoms or would enhance the powers of any political party. Vigilance includes close contact with our elected representatives.

GULLIBLE'S TRAVELS

May 1 — Spoke with **Rep. Deane Davis** of Sioux Falls at the Sioux Falls Lions Club meeting at noon. I discussed health and welfare legislation while Deane handled several other fields.

Thursday afternoon, I drove to Armour,

visiting with **Drs. Mary and Ronald Price** and then talking to the Armour Commercial Club on the Illusion of Security. A large and enthusiastic audience heard the talk.

Sunday noon, May 6, **Mrs. Foster**, the two youngsters and I accompanied **Dr. and Mrs. Pankow** to Watertown where we attended a meeting of the Executive Committee of the Medical Association.

The next week was spent in the office but with Sunday rolling around we were again on our way. This time, **Dr. L. J. Pankow, Dr. J. W. Donahoe** and I drove to Pierre to attend a meeting of the South Dakota Heart Association.

Tuesday afternoon I spent an hour at the Lutheran Welfare office with members of the steering committee of the Governor's Committee on Children and Youth discussing responses we had received to the ideas promulgated at our previous meeting.

On Thursday — the 17th — I drove to Madison to talk to **Dr. Sherwood** who is resigning as secretary of the Board of Medical and Osteopathic Examiners. After an hour with him I went on to Huron to attend a joint meeting sponsored by the Farm Bureau and Greater South Dakota Association on wage and price controls.

Stayed overnight in Huron and left for Aberdeen the next morning where I visited a number of business places to make final arrangements for the Annual Meeting. Talked for quite a few minutes with **Dr. Mayer** at his office.

Drove to Webster to see **Dr. F. F. Pfister** on examining board matters and visited briefly with **Drs. Duncan, Karlins, Lie and Lovering**. Then drove home to relax.

No relaxation — received an invitation to attend a buffet dinner in connection with a convention in Sioux Falls. Went.

CUFF NOTES

Headache Related to Low Back Pain

In a group of seven patients, it was possible to establish a relationship between headache and pain in the lower part of the back.

The back pain was due to abnormalities of sub-fascial fat tissue in the sacral and ilio-lumbar regions. In two cases, preliminary diagnostic injection of local anesthetic provided prompt and prolonged relief of the back pain and simultaneously the backache. In four patients it was necessary to rest the fat tissues. This resulted in complete and immediate elimination of the back pain and the head pain in all cases.

R. J. Dittrick, M.D., Duluth; *Journal Lancet* Feb. 1951.

The Patient Who Makes His Own Diagnosis

Patients who make their own diagnosis of neurosis or difficulties of emotional origin frequently have organic disease, and the reverse is much more frequent, that is patients who insist "something must be found," usually do not have organic disease.

Weis & English — *Psychosomatic Medicine*
Chemical Burns of the Eye

Immediate washing out of an eye with water or isotonic sodium chloride solution is the **only** immediate practice treatment for chemical burns of the eye. This may be followed by a local anesthetic and penicillin ointment. Refer to an ophthalmologist.
W. Morton Grant, M.D.—*JAMA*—Jan. 21, 1950

Pernicious Anemia and Gastric Cancer

Pernicious anemia is the blood brother of gastric cancer. The incidence of stomach cancer in P.A. patients is 5 times as great as in any other individual in the same age group. Cancer of the stomach is a silent lesion.

LOCATION AVAILABLE Balaton, Minnesota

Population 716

Clinic Space on Ground Floor

Physician Serves Population of 2,300

Write
C. J. TENHOFF
Balaton, Minnesota

Patients with P.A. must have routine GI X-ray preferably every 6 months.

John Boeher; *Minn. Med.*—Sept. 1949

FEDERAL SECURITY AGENCY Public Health Service Washington, D. C.

The Nation's death rate from tuberculosis dropped about 9 percent in 1949, to 26.2 per 100,000 population, Dr. W. Palmer Dearing, Acting Surgeon General of the Public Health Service, Federal Security Agency, said today. During the first 11 months of 1950, a further decline of 15 percent occurred, and the rate for this period was 22.6 per 100,000 population, he said, explaining that these figures are provisional, as data for 1949 and 1950 were based on a 10 percent sample of death certificates obtained from each State and the District of Columbia. Dr. Dearing also pointed out that because the death rate for 1950 was based on figures for 11 months only, no aggregate decrease in the tuberculosis death rate since 1948 can be computed at this time.

The death rate in the United States for all forms of tuberculosis has shown a downward trend for almost half a century, except for a slight rise in 1917 and 1918, during the influenza epidemic of World War I.

Since 1900, the death rate for respiratory tuberculosis has decreased 86 percent, from 174.5 per 100,000 population to 24.5, while death rates from other forms of the disease have declined 91 percent, from 19.9 to 1.7 per 100,000 population.

For the year 1949, significant decreases were recorded for men between the ages of 25 and 64 and women between 15 and 64. Data for respiratory tuberculosis, which constitutes over 90 percent of all deaths from the disease, show that the rate for males (32.5) is almost twice as high as the rate for females (16.6). Mortality rates from tuberculosis continue to be more than three times as high for the non-white groups as for the white.

Provisional figures for 1950 show decreases for the age groups between 15 and 74 years. The decreases range from nearly 9 percent for the 65-74 year group to 23 percent for the 25-44 year group. Each of the four geographic regions of the United States showed a death rate decrease for all forms of tuberculosis in 1950.

This is



JUNE
1951
Vol. 4 No. 6

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

NEWS NOTES

Dr. Charles Tesar of Midland has joined the staff of the Pierre Clinic in Pierre.

* * *

Dr. R. K. Morgan, Winner, is leaving the state to specialize in Radiology. His practice will be taken over by a **Dr. Hayes** of Denver.

* * *

Presentation of past-president's certificates and a distinguished service award at the Annual Meeting inaugurated two new ways of recognizing physicians who have contributed to the practice of medicine in South Dakota.

* * *

The 70th Annual Meeting was the first in many to have a three day scientific session. The decision whether to continue a long session or not will be made by the program committee for next year consisting of Doctors **Gregory** and **Jernstrom** and the executive-secretary.

* * *

The Board of Medical and Osteopathic Examiners will meet in Rapid City, July 17 and 18. One of their duties will be to select a new secretary to replace **Dr. Clarence E. Sherwood** of Madison who is leaving the state. Prior to his leaving August 1st, an ap-

pointment to fill **Dr. Sherwood's** unexpired term of three years on the board will be made by **Governor Anderson**.

H. Russell Brown, M.D., Watertown, represented the South Dakota State Medical Association at the A.M.A. House of Delegates in Atlantic City June 11-14. **John C. Foster**, executive-secretary attended the conference of Medical executives.

* * *

Construction on a new \$244,597 hospital in Sturgis was begun this month. A Federal grant of \$119,892 was made to the project.

* * *

Dr. F. J. Bradshaw, Jr. is the new manager of the Ft. Meade Veteran's Hospital near Sturgis. **Dr. Bradshaw** transferred from Gulfport, Miss. to take over the position vacated by **Dr. L. V. Lopez** who was transferred to New York state.

* * *

D. L. Kegaries, M.D., Rapid City, was reelected president of the South Dakota Heart Association at its annual meeting in Pierre, May 13.

* * *

Dr. R. W. McMullen has left Parker, where he has practiced for the past year, to open an office in Tenn-

essee.

* * *

James Y. Clarke, M.D., pathologist at Sioux Valley Hospital in Sioux Falls has left to establish practice in Harlingen, Texas.

* * *

Dr. Jerome Saylor is opening an office in Howard. **Dr. Mead**, who was at Howard a short time is now in the Navy.

ABERDEEN DISTRICT HEARS DERMATOLOGIST

The Aberdeen District Medical Society meeting May 2 at the Sherman Hotel in Aberdeen, had as their featured speaker, **Dr. Elmer T. Ceder** of the University of Minnesota. **Dr. Ceder** spoke on "Common Skin Diseases."

Also on the program was a motion picture titled "Appendectomy" prepared by **Philip Thorek, M.D.** of Chicago.

About thirty-five were in attendance at the meeting.

YANKTON DISTRICT HEARS DR. CUMMINS

Dr. George M. Cummins, Jr., of the department of medicine at Northwestern University was the featured speaker at the Yankton District meeting held at Sacred

Heart Hospital in Yankton, May 23.

Dr. Cummins used as his subject, "Nephrotic Edema" which was well received by the group.

The Auxiliary met with the Society for dinner and then held a separate meeting.

INT'N'L. PHYS. MED. CONGRESS TO MEET

Organized by the British Board of Management of the International Federation of Physical Medicine, the International Congress of Physical Medicine will be held in London from the 14th to the 19th, July, 1952.

In accordance with the regulations of the International Federation of Physical Medicine, the meetings of the Congress will be reserved for matters dealing with the clinical, remedial, prophylactic and educational aspects of Physical Medicine and with the diagnostic and therapeutic methods employed in Physical Medicine and Rehabilitation.

Technical, scientific and historical Exhibitions also will be arranged.

In addition to the Scientific Programme, a full programme of social events and entertainment is being planned for the members and associate members. Arrangements for London and provincial visits of scientific and historical interest are also being made for the Congress week and the following week.

This is a preliminary notice

and full details will be notified later. Applications for the Provisional Programme should be addressed to the Honorary Secretary, International Congress of Physical Medicine (1952) 45, Lincoln's Inn Fields, London, W.C.2.

ARTHRITIS FOUNDATION OFFERS FELLOWSHIP

The Arthritis and Rheumatism Foundation is offering research fellowship in the basic sciences related to arthritis. Fellowships will be granted at both the predoctoral and postdoctoral levels. The predoctoral fellowship will range between \$1,500 and \$3,000 per annum, and the postdoctoral from \$3,000 to \$6,000. The deadline for these applications is November 15, 1951. Application forms may be obtained by writing the Medical Director, Arthritis and Rheumatism Foundation, 535 Fifth Ave., New York 17, N. Y.

TWO WEEK COURSE OFFERED

The Michael Reese Hospital Postgraduate School is offering a two-week course in "Diseases of the Endocrines—Physiology and Diagnostic Methods." This full-time intensive course will meet from July 9th to July 21st, 1951, and consists of a balanced program of basic information and clinical applications. Dr. Rachmiel Levine, Director, Dept. of Metabolic and Endocrine Research is coordinator of the course. For further information, address: Dr. Samuel Soskin,

Dean, 29th St. & Ellis Ave., Chicago 16, Ill.

A full-time intensive course in "Hematologic Diagnosis," under the direction of Dr. Karl Singer, will be presented by the Michael Reese Hospital Postgraduate School from July 23rd to August 4th, 1951. This two-week course offers a review of the present status of hematology and instruction in actual reading of slides of normal and pathological specimens of peripheral blood and bone marrow. For further information, address: Dr. Samuel Soskin, Dean, 29th St. & Ellis Ave., Chicago 16, Ill.

ADMIRAL BOONE NEW V.A. MEDICAL HEAD

Vice Admiral Joet T. Boone, M.C., U.S.N. retired, has accepted appointment as Chief Medical Director of the Veterans Administration. Admiral Boone took over April 1st, succeeding Dr. Paul B. Magnuson.

An interesting report by Dr. Magnuson on why he was "fired" appears in the March issue of Medical Economics.

A.M.A. PUBLISHES NEW BABY BOOK

A new publication by the A.M.A.'s Bureau of Health Education has just been released. The booklet, containing twenty-eight pages, consists of humorous baby pictures and titles with serious comments on child care.

Copies may be purchased from the A.M.A. at 25c per copy or \$12.00 per hundred.

PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor

NEWS ITEMS

Mr. E. E. France druggist at Worthing for the past 30 years died on April 22, 1951. Mr. France had been registered as a pharmacist in South Dakota since 1907. His father and three brothers were all South Dakota pharmacists and they preceded him in death.

Pharmacist James Anderson of Aberdeen is the proud father of a son, Paul Arthur, born on May 14, 1951. James is associated with his father Ernest A. Anderson in the Anderson-Lacey Drug Co.

Mr. and Mrs. Willis Hodson announced the birth of a daughter, Penny Lynn, on May 5, 1951. Willis Hodson is Pharmacist Manager of the Walgreen Drug Store in Aberdeen.

Ted Hustad of the Wall Drug Store donated a new Rx1 Torcion Prescription balance to The Division of Pharmacy. This gift will be greatly appreciated by both the students and instructors.

Mr. and Mrs. Tom Overton ('50) are the proud parents of a baby girl. They are located in Sturgis at the present time.

Mr. and Mrs. Vere Larson of Alcester are also the proud parents of a baby girl. Mr. Larson graduated from the Division of Pharmacy in '44.

Lewis Michaek ('45) has completed his studies for a Medical Doctor at the University of Washington at Seattle and is now taking his internship.

The Junior and Senior Pharmacy students that went to Indianapolis for a tour of the Eli Lilly Pharmaceutical Houses reported a grand time was had by all.

Milton Digre and **Lois Hoffman** were married April 6th at Madison, S. D. **Lowell Sorenson** and **Joanne Triolo** were married March 21st at Eugene, Oregon. Both Milton and Lowell are senior pharmacy students.

Mr. and Mrs. H. I. Ennis of Volga spent the winter vacationing in Arizona. They started home but Mrs. Ennis became ill so they will be staying until she is able to travel home.

PHARMACY GRADS ACCEPT JOBS IN BLACK HILLS AREA

Forty students who will be graduated from the division of pharmacy at South Dakota State college will take the state board of pharmacy examination June 5, 6, and 7 according to Dr. F. J. LeBlanc, dean of pharmacy at State college.

Members of the state board of pharmacy who will administer the examinations in Brookings will be Floyd Cornwell, Webster; M. C. Beckers, Rapid City; Harold Tisher, Yankton, and Bliss Wilson, Pierre. Wilson is secretary of the board.

Dr. LeBlanc reports that demand for the graduates this year is good; in fact most of the graduates have already accepted positions.

All the women have accepted jobs, but some of the men have only tentatively taken positions because of expected military service.

Those who have accepted jobs include: Mary Ann Kohler, Brookings, Mills Drug company, Rapid City; Rodney Meyer, Carthage, Hazeldine Pharmacy, Spearfish; Carol Opheim, Hot Springs, Bittner Pharmacy, Aberdeen; Alfred Raynes, Andover, Jones Drug store, Custer; Maxine Williams, Salem, Mills Drug, Rapid City; Timothy Ryan, Aberdeen, Newell Drug, Deadwood; Robert Kerl, Pawnee City, Neb., Mills Drug, Rapid City; and Milton Digre, Hendricks, Minn., Lehr Drug, Rapid City.

MARK NAMED TO HEAD PHARMACISTS

S. L. Mark, Aberdeen, was elected president of the Aberdeen District Pharmaceutical society at a meeting here. **Willis Hodson** was named vice-president; **Bernard Bittner**, secretary-treasurer, and **Norma Aspen**, corresponding secretary. All are from Aberdeen.

A. O. Bittner, Aberdeen, was elected to the executive board. The meeting was held in the basement of the Municipal building and was conducted by Bittner. Community singing was led by Lt. Walter Kennedy of the

Salvation Army. Lt. Kennedy was guest speaker.

The election of officers followed a report by L. A. Daniels, chairman of the nominating committee. A film, "The Quarterback," was shown followed by a lunch served under the direction of Jim Cameron.

DR. HUGO H. SCHAEFER TO RECEIVE 1951 REMINGTON MEDAL AWARD

Dr. Hugo H. Schaefer, Treasurer of the American Pharmaceutical Association, Dean of the Brooklyn College of Pharmacy, and widely known as an officer of many pharmaceutical organizations, will receive pharmacy's highest honor, the Remington Medal, according to an announcement issued today by the American Pharmaceutical Association. The medal, given by the Association's New York branch, will be presented at a dinner in New York in the fall. The Remington Honor Medal may be given annually to the individual who has done most for American Pharmacy in the previous year, or whose continuing contributions to the advancement of the profession have been outstanding.

The past presidents of the American Pharmaceutical Association serve as the jury of award. In giving their reasons for the award to Dr. Schaefer the past presidents referred to his intense unselfish service to the profession over the past 30 years. They also cited his diplomacy in uniting the efforts of various groups engaged in controversies over methods when all are working for the same principle; his leadership in the development of sound educational procedures in American Pharmacy; his outstanding contributions to the work of U. S. P. and N. F. revision; his very helpful contributions to the solution of problems involving food and drug legislation and his public services as chemist to the New York Board of Pharmacy and adviser to health agencies and to the War Production Board in World War II.

FOOD AND DRUG ADMINISTRATION ASKED TO INCLUDE PHARMACIST ON TOP ADMINISTRATIVE STAFF

The Food and Drug Administration is asked to include an administrator with a pharmacy background in its top administrative staff in an editorial appearing in the current issue of

the Practical Pharmacy edition of the Journal of the American Pharmaceutical Association.

It is pointed out by Dr. Robert P. Fischelis, Editor of the Journal, that the Food and Drug Administration has a commissioner, an associate commissioner, and an assistant commissioner to deal with the various administrative functions, plus department heads for medicine, chemistry, pharmacology, bacteriology, and other specialties, but that now where on this upper administrative level is there a pharmacist or an individual with a background of actual experience in pharmacy, either manufacturing, control, dispensing, or distribution.

"This situation accounts, in a very large measure, for the failure of the Commissioner of Food and Drugs and his associates to give adequate advice to the Federal Security Administrator on the issuance of regulations dealing with the production and distribution of drugs," the editorial states.

Previous public references to this lack of outstanding pharmaceutical administrators has been met with the argument, according to the editorial, that somewhere down the line in the Food and Drug Administration there are graduates of pharmacy colleges engaged in inspection work or in review of laboratory findings and reports of inspections.

"None of the official spokesmen of the Administration, as far as we know, has had any formal education in pharmacy," the editor states. "There must be recognition of the fact that a very large part of the work of the FDA deals with drugs and therefore it is essential that personnel trained in drugs shall be appointed to the Administration's staff to carry weight in the development of regulations and policies with respect to law enforcement."

Prescribe
Journal
Advertised
Products

Carcinoma of the Prostate Gland*

William J. Baker, M.D., Chicago, Illinois

Carcinoma of the prostate gland, according to a recent Public Health Report, is the third most common cancer. It is outranked in frequency by carcinoma of the stomach and skin. It has been estimated that carcinoma of the prostate gland is found in approximately 5 per cent of all men who reach the age of 60 years. Some pathologists state that cancer is found in approximately 20 per cent of all prostates, which are removed for benign hyperplasia. It can be said that 20 to 30 per cent of all men who complain of prostatism, will, in the final analysis, be found to have cancer of the prostate gland. This incidence is alarming and requires earlier and earlier diagnosis if these unfortunate men are to have the benefit of curative procedures.

The majority of prostatic cancer patients are between 60 and 80 years of age. Ten per cent are between 50 and 60 years of age. Very few instances are found below the age of 50. Occult cancers of the prostate follow the same incidence in the stated age groups except more occult cancers are found after 80 years of age.

A clinical discussion of cancer of the prostate gland places the patients into two distinct groups. Group I includes those patients who have no urinary symptoms but in whom rectal examinations reveals a suspicious infiltration or a small nodule. The number of patients in this group is very small and comprises about 5 per cent of all prostatic cancers. Group 2 embraces the large number of patients in whom there may be urinary symptoms and an infiltrated, irregularly enlarged, hard prostate gland with or without metastatic pain, and with or without clinical evidence of metastases. Those patients in whom the tumor has broken thru the confines of the prostate gland but no distant metastases can be demonstrated, comprise about 20 per cent of all prostatic cancers.

Thus, it is readily deducted, that 75 per cent of all prostatic cancers have not only broken thru the confines of the prostate when first seen but also are accompanied by demonstrable distant metastases.

Our greatest curative hope lies in that group of men whose early diagnosis depends on routine rectal examination by physicians who are doing periodic physical examinations. One cannot emphasize too strongly the importance of the family physician, or the internist, in this picture of early diagnosis of cancer of the prostate gland. There may be found a very small nodule in either lateral prostatic lobe, or more likely in the region of the posterior prostatic lobe or more properly called the posterior lamella. This latter region is most easily palpated by rectum and embraces the region between the verumontanum and the external urethral sphincter. If a suspicious area is detected by rectal examination, usually in the absence of symptoms, it is indicated to hospitalize the individual, make a perineal exposure of the questionable area, excise a portion of the nodule or infiltrated area for frozen section study and do a radical perineal prostatectomy if cancer cells are found. If no cancer cells are found, revision of the vesical neck can be done, if indicated. Sometimes there are no obstructive symptoms or obstruction and the perineal wound is closed.

Biopsy of tissue from these suspicious areas has been attempted by needle aspiration thru the perineum, but the results have not warranted general and exclusive use of the method. Pathologists have found it difficult to offer a conclusive opinion from the small bits of tissue often recovered for study. A definite positive finding is the only finding of value.

It is also stated by some workers that suspicious symptomless areas of the prostate can be biopsied by transurethral resection. When one recalls that most of these early prostatic cancers originate in the compressed glandular tissue of the surgical capsule of the prostate

* Presented at the Seventieth Annual Meeting of the South Dakota State Medical Association, Aberdeen, S. D., June 4, 1951.

gland, it is realized that the resectoscope loop may never reach the suspicious areas.

The above points can be illustrated best by the report of Mr. H. H. F., age 64, who was examined by a diagnostician in May 1942 because of shortness of breath. Routine rectal examination revealed a small hard nodule in the right lateral prostatic area adjacent to the posterior lamella and probably incorporated within it. He had experienced nocturia two to three times for the past ten years. His general physical condition was excellent. Blood studies and chemistry figures revealed nothing significant. Roentgen studies of the lower spine and pelvis revealed no metastatic lesions. Observation cystoscopy revealed a moderate-sized glandular median prostatic bar. The nodule of the right lateral prostatic area could be an area of chronic prostatitis, a calculus or an early malignancy. There was no finding of prostatic calculi by roentgen ray.

Tissues from the indurated area of the right lateral prostatic area, obtained by perineal exposure and studied in a frozen section, revealed cancerous changes. A radical perineal prostatovesiculectomy was done. The patient made an uneventful recovery. He is now in his 9th postoperative year and is in good health. Rectal examination reveals a flat, soft and non-tender prostatic bed. The histological report of the indurated area was as follows: These tissues have a background of smooth muscle and fibrous stroma. Along one side are medium sized and larger prostrate gland acini with columnar lining cells. Forming most of the small tubules with columnar cells are without an orderly structure. They extend as small cords into the stroma tissues. There are several medium or large acini with a hyperplasia of the lining cells into the lumen. The tissue pattern deviates considerably from that usually seen with glandular hyperplasia. The small tubules and compressed cords seem to have grown into the supporting stroma. This is a small carcinoma of the prostrate gland.

This patient emphasizes again that early prostatic cancer is most likely to be discovered as an incidental finding in routine rectal examination of males. It is repeated that the most common primary site for prostatic cancer is the posterior lobe or lamella

which is also the portion of the gland most easily palpated by the examining finger in the rectum. The cancer may be first felt as a solitary nodule, unless there is an associated hyperplasia or prostatic bar. The statement is found in the literature that any prostatic cancer which can be diagnosed by rectal examination is beyond any possibility of a surgical cure by radical removal. To this statement we most certainly take exception. We have seen quite a few relatively inactive lesions which have remained within the capsule for a long time and are easily palpated as hard nodules by rectal examination and have been completely eradicated by radical prostatectomy. However, we also know that extra capsular perineural lymphatic transmission of cancer cells may occur so early that chances for cure have passed long before the primary lesion can be definitely diagnosed except by microscopical pathological study. Even so, there seems to be some logical basis for complete removal of these small cancers, if technically possible even when extracapsular metastases are present. By such removal, all prostatic obstruction is removed and, it is now known, that associated metastases offer a better chance for hormonal control after the primary lesion has been removed.

That even the small nodule has already metastasized and the radical prostatectomy does not prevent a rapid recurrence is well shown in the following history. Mr. J. J., age 58, who was admitted to the hospital 7th September 1945, complained that he had had a nocturia 3 to 5 times for the past 3 years. There had been a marked day frequency for the past 3 or 4 months. His urinary stream had been growing smaller for the past 18 months and it was now difficult to start the act of voiding. There was no complaint of pain. He looked well. The rectal examination revealed a grade 3 prostatic enlargement, the right lobe being larger than the left and carried a good sized hard nodule. The residual urine was 3 ounces.

The remainder of the physical examination was without import. Roentgen studies revealed osteophytes of the bodies of the lower lumbar spine. There were no metastatic lesions of the lumbar spine or pelvis. Blood and blood chemistry studies were normal.

A perineal exposure was made. A biopsy

of an indurated area from the superior pole of the right lateral prostatic lobe, revealed cancer. A radical prostatovesiculectomy was done. The convalescence was uneventful.

The removed tissue presented prostatic hyperplasia with active cancer. Some cells were in mitosis. There were invasions of tumor cells around large nerve trunks, especially of the capsule. Some of the perineural lymph channels were filled with cancer cells.

This patient had symptoms of prostatism, and a prostatic nodule which was hard enough to be cancer. Although roentgen studies excluded metastatic bone lesions, in less than 10 months postoperatively, in spite of adequate hormonal therapy and castration, this man began to have bone pain of the pelvic and perineal regions, loss of weight, lack of appetite and malaise. Roentgen studies then showed many metastatic bone lesions of the lumbar vertebrae and pelvic bones. This patient died just 15 months after his radical prostatectomy.

The lesions which are most confused with early prostatic cancer are chronic inflammation, tuberculosis and prostatic calculi. For example, Mr. W. K., age 63, presented himself with the history that his family physician had discovered a nodule in the left lateral prostatic lobe 3 months ago during an annual physical examination. He had consulted 2 urologists. One had told him that the lesion was inflammatory because the expressed secretion contained many pus cells. The second urologist expressed concern over the probability of the presence of cancer. The only urinary symptom was nocturia one time. This man was in good physical condition except for a moderate hypertension. Rectal examination disclosed a rather limited nickel-sized infiltrated area high in the left lateral prostatic lobe. This area was not fixed. The blood picture was normal. Roentgen studies showed rather extensive osteo-arthritis of the lumbar spine and normal pelvic bones. Infiltration in the lateral edges of the prostatic lobes speaks strongly for the diagnosis of chronic inflammation. A perineal approach to the prostate gland was made, the infiltrated area located, a piece excised and sent for frozen section study. No cancerous tissues were found. The prostatic capsule and wound were closed. The patient made an unevent-

ful recovery. His chronic prostatovesiculitis has responded well to local management.

There is a microscopical study of some tissue obtained by perineal exposure from a 48 year old male who had a hard nodule in his upper left prostatic lobe. It showed the usual smooth muscle and fibrous stroma and small acini with cuboidal or low columnar lining cells of the prostate gland. A few of the acini contain corpora amylacea. The exudate cells are lymphocytes, plasma cells, mononuclear phagocytes and a few polynuclear leucocytes. At one place, there is a giant cell that suggests a Langhans cell. Another lesion has more of the structure of a tubercle and contains several giant cells. Histologically the inflammation suggests tuberculosis. No tubercle bacilli were ever recovered from the urine. Roentgen studies of his lung fields showed a great deal of infiltration and a number of calcified areas. Ten years have now passed. The rectal examination of this man reveals the same findings as originally described. He has no urinary symptoms. He probably represents a healed prostatic tuberculosis.

In some instances, roentgen studies will not reveal prostatic calculi and a perineal exposure is necessary to exclude a cancer of the prostate gland.

Hugh J. Jewett of Johns Hopkins Hospital has analyzed 190 cases of radical perineal prostatectomy for cancer of the prostate gland. He makes the following conclusions. "Radical perineal prostatectomy is a relatively simple procedure. The operative mortality is about 3 per cent, and the incidence of postoperative disability is low. In properly selected cases the 5 year survival rate, without recurrence, is 51.3 per cent.

The 10 year survival rate is 28 per cent. Until it can be demonstrated that the conservative management of a comparable group of microscopically proved cases will yield as high a percentage of 10 year survivals, radical perineal prostatectomy remains the procedure of choice for early cancer of the prostate gland." We concur in these conclusions wholeheartedly.

The big majority or about 75 per cent of patients who are first seen for cancer of the prostate gland, have rather marked urinary symptoms, radiating pains either of the back, perineum or legs and a markedly indurated

nodular and often a fixed prostate gland. Prostatism with associated pain should cause suspicion of cancer at once even though there be no suspicious palpatory evidence of the lesion. It should be borne in mind that all prostatic cancers are not hard and fixed. A few are soft but cause pain. This pain of prostatic cancer, whether it be hard or soft, may be of a deep pelvic type or associated with urination. It has been shown pathologically that there is a marked tendency for early involvement of perineural lymphatics both intra and extra capsular. Thus this symptom of pain is readily explained. It is recognized that the histological pathology in itself is not important except that most prostatic cancer is adenocarcinoma. Squamous cell carcinoma of the prostate gland occurs rarely. It has been noted by clinicians that a sudden acute retention in a man who has had few or no previous urinary symptoms, very often occurs in those with carcinoma of the prostate gland. Some of these men exhibit systemic symptoms of malaise, loss of weight and appetite, and a secondary anemia. Occasionally these symptoms are present due to a cancer of the prostate gland which has not yet produced urinary symptoms. The first sign of a new growth of the prostate gland in a small number of these patients is a fracture or osseous lesion due to metastases from the prostatic cancer.

Demonstrates ebonization and areas of destruction in the vertebral bodies in a man with cancer of the prostate and very few urinary symptoms.

Shows similar involvement of the bony cage of the thorax.

Demonstrates a metastatic lesion of cancer of the prostate in the upper end of the humerus.

At this point, it should be stated that much work has been done on the study of the enzyme phosphatases of the blood serum in connection with carcinoma of the prostate gland. The enzyme acid phosphate is found normally in high titre in the normal adult prostate gland. It is a content of adult prostatic epithelium. The gland cell of prostatic cancer possesses the physiological capacity for the production of the enzyme and phosphate. So, it is a tissue specific substance, a marked increase of which is found in the blood serum **only** in prostatic carcinoma

with dissemination beyond the prostatic capsule, especially into the lymph nodes or bone marrow spaces. It should be emphasized, however, that in some patients with prostatic carcinoma with definite bony and other metastases, the serum acid phosphatase values may be within normal limits. On the other hand, some patients with a prostatic cancer with no roentgenologic evidence of metastases are found to have significant elevations of the serum titre of this enzyme. According to Nesbit, "the discovery of an abnormal serum acid phosphatase level in the absence of evident metastases in a patient with prostatic cancer carries with it the implications of poor prognosis, for the patient with this finding has considerably less chance for three year survival than does the person in the same circumstances whose serum acid phosphatase is normal. The finding of a normal serum acid phosphatase value in a patient with metastatic prostatic carcinoma does not necessarily imply poor response to endocrine therapy by reason of the assumption of androgen independence on the part of the cancer cell, for, in general, these patients exhibit the same, or a greater, degree of benefit from treatment than do patients who have an elevated serum acid phosphatase level."

Alkaline phosphatase increase in the serum of man indicates osteoblastic activity or liver disease, hence is non-specific as far as carcinoma of the prostate gland is concerned. This increase is observed in other bone lesions such as Paget's Disease and sarcoma. It is obvious then that both acid and alkaline phosphatase determination should be made in a clinical study of carcinoma of the prostate gland. No other disease is known to show a concurrent elevation of both types of phosphatase. In the presence of prostatic carcinoma with elevated serum alkaline phosphatase and without evidence of gross liver damage, the possibilities are that bone metastases exist even though not yet evident by the roentgen ray.

Therefore, a completely studied patient, where carcinoma of the prostate is considered, should have both acid and alkaline phosphatase determination, but the clinician should be fully aware that, the evidence obtained is only corroborative. However, investigators agree that a high titre of acid phosphatase (King Armstrong Units 5 plus)

probably indicates the presence of carcinoma of the prostate gland with extra capsular extension. It is also agreed that a high titres of both acid and alkaline phosphatases indicates the presence of carcinoma of the prostate gland with bone metastases. That many patients with all stages of carcinoma of the prostate gland may have normal serum phosphatase levels, is generally known.

There is the occasional patient who has pelvic pains, loss of weight and appetite and no urinary symptoms. His prostatovesicular bed feels benign and is not enlarged. Phosphatase levels are normal. Cystoscopy affords no positive findings. T. P., age 48, was such a patient. Sternal puncture revealed nests of prostatic cancer cells. Prostatic tissue was obtained by transurethral methods and revealed definite prostatic cancer. Castration and estrogens afforded relief of all pain, return of appetite and gain of weight.

The treatment of this group of patients should correct the vesical neck obstruction, if present, improve the general condition of the patient and control the growth of the cancer. Twenty five years ago, if a cancerous prostate were producing obstructive urinary symptoms, a cystotomy was done and the patient treated palliatively with opiates until he died of urosepsis or some concurrent disease. About 1931, transurethral prostatic resection became popular to relieve the bladder neck obstruction from cancer of the prostate gland. It was realized that the growth would rapidly refill the prostatic urethra and repeated transurethral resections would be necessary. It was also realized that it would still be necessary to use many drugs and procedures to control metastatic pain. About 10 years ago, workers discovered that castration, either surgical or by roentgen rays, improved the general condition of the prostatic cancer patient, caused the prostatic cancer to recede in size and to soften in consistency and the metastatic pain would often disappear or improve. The metastatic bone lesions would improve or disappear. The obstructing cancerous prostate gland would atrophy so much in some instances that revision of the vesical neck would not be necessary to relieve obstruction. Hormonal studies soon revealed that maintenance doses of estrogens produced a chemical response similar to that produced by castration in most

cases.

With the above facts in mind, the first prerequisite to the treatment of this large group of patients is a positive diagnosis of cancer of the prostate gland. This can be done by a study of the prostatic tissue which is removed in the transurethral revision of the obstructive vesical neck, or by a study of tissue obtained thru a perineal biopsy. This positive diagnosis will obviate the unnecessary use of estrogens and the promiscuous use of castration.

Today there are two distinct opinions about the treatment of these obvious prostatic cancers. One group of workers advise correction of the vesical neck obstruction by transurethral resection, with an immediate bilateral orchiectomy, hormonal bombardment with large doses of an estrogen and a course of deep roentgen therapy. There is no doubt that this course of action permits a longer survival and a more comfortable life. It is not always easy to sell the patient such a plan of treatment. The other group of workers advise a transurethral revision of the vesical neck and the administration of a daily maintenance dose of an estrogen. If the metastases or the metastatic pain cannot be controlled by the estrogens or the general condition of the patient is downward, a bilateral orchiectomy is done and a course of deep roentgen therapy is given.

There is now a third course of action available. Endocrines can be administered until the prostatic cancer is no longer palpable. Then a radical perineal prostatectomy can be done. Quite a few patients lend themselves to this course of action. It is thought that the hormones will prolong life longer when as much of the primary lesion has been removed as is possible.

A few workers have administered the hormones to these advanced prostatic cancers until the maximum hormonal effect has been obtained, then do a complete viscerectomy of all involved organs. I have had no experience with this procedure.

It is generally agreed that all of these patients who do not lend themselves to radical surgery, should have bilateral orchiectomy and adequate doses of estrogen.

A most dramatic response is seen after orchiectomy of patients with the far advanced carcinoma with metastases, cachexia

of malignancy, secondary anemia and imminent death. It is not uncommon to see this clinical picture change immediately after orchiectomy to one of progressive improvement. There is relief of pain, gain of weight, return of appetite and a return to normal ways of life and work. This result can be obtained in no other way, in our experience. The maximum result is obtained by the follow-up use of maintenance doses of estrogen postoperatively.

It is generally known that if one of these patients is given an estrogen and then stops its use, resumption of the estrogen will never again be as efficacious had he continued its use without a rest period. The occasional patient is intolerant to estrogens. After a 4 to 13 day course of A.C.T.H. (150 to 200 mgms.) some of these patients tolerate estrogens very well.

There was a tendency for awhile, to increase the dose of estrogens. This has been carried to the astounding dosage of 30 milligrams of stilbestrol a day. The clinical change does not warrant such dosage. Not only were there no important increased benefits, but the side effects of painful and enlarged breasts, ankle edema and gastrointestinal disturbances soon caused the general return to maintenance doses usually equivalent to 2 to 3 milligrams of stilbestrol a day. Experiments on rats and mice, using large doses of stilbestrol, have clearly demonstrated liver cell damage, also hypertrophy and dilatation of bile ducts.

In the occasional patient, castration and endocrine therapy will not control the pain from prostatic cancer. A series of deep roentgen therapy treatments will often give prompt relief from this pain. A few workers have applied deep roentgen therapy to the pituitary gland to obtain relief of pain in prostatic cancer.

There is a group of patients in whom the biological equation allows the cancer of the prostate gland to grow slowly and they live their normal span of life in a fairly comfortable state. In the light of our present knowledge one could suspect that these new growths are held in check by a favorable hor-

mone reaction or that the growth is slow because the stimulating hormones are lacking. It is a well known fact that many of these prostatic cancers in men who are in the 7th and 8th decades of life, are very slow growing and metastasize very slowly. These facts must be considered when one talks of prolonging life with castration and estrogens.

It is a fact that these men certainly finish their span of life in relative comfort, because of our endocrine therapy. Their longevity is increased varying periods of time. One cannot prophesy the longevity but one can promise relative comfort to these patients.

Nesbit has followed up 783 patients with prostatic cancer treated before 1940 and found that 69.4 per cent had died by the end of the second year after diagnosis. Similar data were secured from the literature on 569 patients treated by castration, estrogens or both. Thirty per cent of these patients had died by the end of the second year; i.e. about half the patients who might have died without endocrine therapy were still living. Rusche has found that deep roentgen therapy, if added to castration and endocrine therapy, gives the longest span of life.

Nesbit and Baum state that 3 and 5 year survivals are significantly greater in endocrine-controlled patients than among others. Castration alone and diethylstilbestrol alone appear to have about the same value when metastases have not yet occurred, but combination of the two provides a survival advantage over either alone. In patients with metastases the influence of castration and or estrogen on longevity is still effective but to a lesser degree. So, metastases have a grave prognostic significance.

In summary, the small cancer of the prostate with no evident metastases deserves a radical perineal prostatectomy. If the cancer has spread beyond the confines of the surgical capsule of the prostate gland, a transurethral revision of the obstructive vesical neck, a bilateral orchiectomy, hormonal bombardment and deep roentgen therapy, should all be done, to obtain the most comfortable patient and the longest span of life.

The Ocular Mucous Membrane of Erythema Multiforme Exudativum

By George H. Spurbeck, M.D., Pierre, S. Dak.

R. B., a 34 year old white male entered St. Mary's Hospital February 14th, 1951, complaining of sore throat and a rash — covering his trunk and extremities. His illness began four days prior to admission. At this time, he had a marked sore throat — the throat and mouth became progressively worse and just prior to admission, he noticed the rash on his trunk and extremities.

Family and past history are not contributory.

Physical examination revealed a well developed, well nourished white male — who appeared acutely ill. His oral temperature was 102° F., pulse 88, rate and rhythm regular. Respirations 24 — breathing not labored. Both eyes showed a marked catarrhal conjunctivitis, but no purulent exudate was seen. Photophobia was present. In the mouth, there were numerous grayish-white patches along with shallow necrotic ulcers which bled when touched. The white patches, when removed, revealed ulcers in various stages of formation. There was a fetid odor to the breath and the patient complained of intense pain in the oral region. The submaxillary glands were palpable but not tender. The chest was symmetrical and its expansion was free and even bilaterally.

The heart was not enlarged to percussion. Point of maximum impulse was in the fifth interspace, mid-clavicular line, rate and rhythm regular — with no murmurs. The lungs were clear to percussion and auscultation. The blood pressure was 130/80. The abdominal examination was negative for masses and tenderness and no enlargement of the liver or spleen were noted. The inguinal lymphnodes were palpable but not tender. The neurological examination was negative. There were numerous lesions of the annular macular type present — symmetrically distributed on extremities, trunk and penis. The most prevalent lesions were of the iris type, with

the center being of violaceous hue and the margin bright pinkish in color. The macular and papular lesions were more numerous over the extremities, abdomen, and chest, while the vesico-bullous lesions were present in the mouth and on the glans penis and a marked balanitis was noted. The lesions did not itch.

*Laboratory results on admission were as follows:

Blood: Red blood cells	4,920,000
Hemoglobin	14.5 grams
White blood cells	15,100
Differential: Neutrophils	90%
Lymphocytes	4%
Monocytes	4%
Eosinophile	2%
Venous coagulation time—	7 minutes
Wasserman—	negative

Urine: Specific gravity	1.013
Sugar, albumin, cast and cells—	negative

Slides negative for monilia albicans.

Smears from the throat and gums reveal numerous fusiform bacilli present and later was reported positive for *Spirella Vincenti* from the State Laboratory.

On February 16, 1951, the white blood count was 9,000 with neutrophils 76 per cent, lymphocytes 20 per cent, monocytes 3 per cent, eosinophils 1 per cent.

Treatment on admission consisted of **Ab-bocillin, 600,000 units, codeine phosphate, grains 1 every four hours for pain; sodium perborate mouth wash. On February 18, 1951, ***Chloromycetin, 500 mgm., four times a day, was instituted and tolerated very well by the patient with no side reactions. I conclude that it was of a very definite benefit to the patient. Supportive intravenous therapy consisting of amigen and glucose solutions was given. Penicillin therapy was discontinued when Chloromycetin was started.

The progress of the patient was as follows:

On February 14, 1951, slight epistaxis was noted. On February 15, 1951, the patient still complained of severe pain in the mouth and throat and was unable to take a liquid diet. On February 16, 1951, a purulent exudate was noted beneath the foreskin. On February 20, 1951, the patient felt better, and gradually improved with clearing of all signs and symptoms. The patient was discharged from the Hospital on February 24, 1951.

DISCUSSION: The etiology of erythema multiforme is still unknown. It has been suggested that it might be viral in nature; this was the reason for changing from penicillin therapy to chlorophenicol. One must consider an allergic type of reaction or manifestation, although the nature of the allergen is in doubt. As far as the value of either Cortisone or ACTH, I quote: ****"In my experience, neither Cortisone nor ACTH have been of any value in treating this complex. I have had two cases treated with these drugs and neither of them responded. When they were discontinued and aureomycin and chloromycetin were used — excellent results were obtained."

SUMMARY: A case has been presented which has been grouped under various headings, such as: bullous, malignant erythema multiforme (eruptive fever with stomatitis, and ophthalmia), ectodermosis erosive pluriorificialis, dermatostomatitis, Behchet's Disease, or Stevens-Johnson's Disease. All are terms which have been used to describe a clinical picture. The above names describe a symptom complex in which many findings are similar or vary only in degree of severity. At times, one group of symptoms, such as the ocular, will predominate and perhaps overshadow other findings. In accordance with the suggestion of *Harry Robinson, Jr., M.D., it would be wise to group these entries under the term "ocular mucous membrane

*From the Pierre Clinic and St. Mary's Hospital, Pierre, South Dakota

**T. M. Abbott Laboratories (penicillin G)

***T. M. Parke-Davis Company (Chlorophenocol)

****Personal communication from Harry M. Robinson, Jr., M.D., Baltimore 2, Maryland

*Robinson, Harry M., Jr.: "The ocular mucous membrane syndrome": **"The Medical Clinics of North America,"** Volume 35, Number 2, March 1951.

syndrome of erythema multiform exudativum."

REFERENCES:

1. Sutton, Richard L. and Sutton, Richard L., Jr.: **Handbook of Disease of the Skin**, The C. V. Mosby Company, St. Louis, Missouri, 1949: page 497.
2. Sulzberger, Marian B. and Wolf, Jack: **Dermatologic Therapy in General Practice**: The Year Book Publishers, Inc., Chicago, Illinois, 1943: page 372.
3. Pillsbury, Donald M. and Sulzberger, Marian B. and Livingood, Clarence S.: **Manual of Dermatology**, W. B. Saunders Company, Philadelphia, Penn.: 1942.
4. Robinson, Harry M., Jr.: **The Medical Clinics of North America**, The W. B. Saunders Company, Philadelphia, Penn., March 1951: Volume 35, Number 2.
5. Robinson, Harry M., Jr., M.D.: Personal Communication with the Author.

MEDICAL EDUCATION'S GREAT NEED

Our country is experiencing a searching interest in medical education which is not only stirring the social consciousness of the nation, but is also arresting the attention of the profession itself. Physicians are being vigorously attacked for their intransigent social, political, and economic attitudes while at the same time almost every family has a son or a daughter, a nephew or a niece enrolled in a premedical course.

Greater numbers of our youth than ever before are seeking entrance into medical schools. Recent medical graduates by the thousands are looking toward the further educational experience of residency training in the medical specialties. A legion of practicing physicians is seeking out and attending the ever increasing number of postgraduate courses given throughout the nation.

What motives lie behind this feverish quest for medical knowledge? The stimulus of science is undoubtedly there. It prods the intellect today as it always has. There is, however, an inferior motivation, a kind of pragmatic urge which is undermining the old ideals of medicine. "Short cut" courses and "quick reviews" are being encouraged in order to give the practical answers. The ideal of medical education from this point of view seems to be the acquisition of more and more "rules of

thumb" for a more efficient and business-like type of practice.

The young student today seems to be less interested in Pasteur than in quickly getting into an office or clinic building of his own. Early marriage and an established practice rather than medicine itself are apt to be his goal.

Rather than being judged for their success in improving the professional soul, medical educators are today frequently criticized by practitioners for failing to teach students how to run an office, keep a set of books, fill out income tax returns, write board examinations, find a location in which to practice, and fight the evils of socialized medicine. The over-emphasis of this is an expression of an unwholesome philosophy which is growing into medicine.

Let us safeguard the fires of our profession. Our heritage must be protected and the old ideals must be kept aloft.—John S. Hirschboeck, M.D., Dean, Marquette University School of Medicine, in Wisconsin Medical Journal.

"Dakota GP"

General Practice in South Dakota has developed a wealth of experiences that could be written into narrative form. One of these experiences has been told by a man who has practiced many years in the south-central part of the State, and who was only recently named General Practitioner of the Year by his associates.

This doctor tells of the time that he was called over almost impassable roads to the home of a seriously ill man twenty-five miles from the doctor's office. After tortuous hours of travel, the doctor arrived to learn that the patient had a strangulated hernia which demanded immediate surgery. The doctor called a colleague of his from another small town to hurry out to assist him, and as he waited, he lined up the standard equipment for kitchen surgery.

A boiler was pressed into service to sterilize the few instruments the doctor had brought with him. Lights consisted of two kerosene lanterns and a flashlight. In the semi-darkness the two surgeons finished what surgery

they could do. They left the house with little hope that the patient would survive the night.

The next day, the family called and reported that the patient was still alive but would need further care. With fingers crossed, an order was given to bring him into town as soon as possible. This was done three days later by bobsled. Being without a hospital, the doctor performed a resection in the hotel where some kind of nursing was available. After a long illness, the patient recovered and was returned to his home.

In due time the grateful patient published a notice in the local newspaper thanking the band for playing for him, the Ladies Aid for bringing him flowers, and the Good Lord for bringing him through. And the doctor who had sweat blood to bring the patient through? He wasn't mentioned

* * * *

This same GP tells of the uneducated but not so ignorant Indian who devised his own ice pack cooling system for an acute attack of appendicitis. When the doctor arrived at the poor Indian's hovel the fellow was in fair shape due to his self-devised system. He had two pint jars filled with water. When one was soothing his painful abdomen, the other, still within reach, was outside the window being cooled. When the first warmed up, the second was exchanged for it. As the doctor puts it "Lo, the noble Redskin"

VASCULAR DISEASE AND DIABETES

Vascular disease is more frequent and severe in diabetics in whom the disease begins in the first or second decade and who survive more than 15 years than in those with an onset in middle life.—W. S. R. in Detroit Medical News.

Prescribe
Journal
Advertised
Products

Chemotherapy of Cancer

Robert P. Hohf, M.D.*

Evanston, Illinois

Chemotherapy is the most important aspect of cancer treatment at the present time. Although it cannot compete with surgery and irradiation in offering cures as yet, it exceeds them in importance for two reasons. First, it is providing invaluable information about the nature of cancer which probably will lead to the eventual cure of most neoplastic diseases, and second, it is all that is available to the majority of cancer patients now. Of the approximately 800,000 cancer cases in the United States only about 20% can be salvaged for 5 years.¹ The remainder receive palliative care alone, and in the field of palliation chemotherapy offers more hope than any other measure.

There are a number of possible sites of chemotherapeutic attack on cancer that have been postulated.² Direct action on the neoplastic component of the cell, if there is any, is a possibility. The normal part of the cancer cell can be affected as in the use of nitrogen mustards and urethane. Mitosis can be inhibited as exemplified by the action of colchicine. The tissue defense reactions against cancer can be supported and stimulated as in the use of antireticular cytotoxic serum (ACS). Influencing the cell environment affords an indirect way of inhibiting the cancer cell as is thought to occur with hormones. Impairing the vascular supply as is done by polysaccharides is another method. Finally, the metastatic tendency, invasiveness, and general debilitating characteristics of cancer also may be avenues of approach to the successful treatment of the disease.

Some of the chemotherapeutic materials

Born and raised in Yankton, South Dakota.
AB Oberlin College, Oberlin, Ohio, 1942.
MD Northwestern University Medical School, 1946.
Internship Wesley Memorial Hospital, Chicago, 1 year (1945-'46).
Medical Officer Army of the United States 2 years (1946-'48).
Pathology resident Evanston Hospital Association, Evanston, Illinois, 6 months (1948).
General Surgery resident Veterans Administration Hospital, Hines, Illinois, 2½ years (1949-'51).

that have been investigated can be classified according to their types of action, as follows:³

A. Environmental agents.

1. Hormones.

- a). Androgens.
- b). Estrogens.
- c). ACTH and Cortisone.

B. Growth inhibitors.

- 1. Carbamates (urethane).
- 2. Nitrogen mustards (methyl-bis).
- 3. Folic acid conjugates (teropterin).
- 4. Folic acid analogs (aminopterin).
- 5. Radioisotopes (I^{131} , Au^{198} , P^{32}).

C. Selective cell poisons.

- 1. Bacterial products (polysaccharides).
- 2. Antireticular cytotoxic serum (ACS).
- 3. Stilbamidine.
- 4. Viruses.

The sex hormones, particularly the androgens, are the best examples of beneficial chemotherapy of cancer. The relationship of male hormones to cancer was first suggested when it was noted that orchietomy incident to herniorrhaphy caused regression of benign prostatic hypertrophy.¹ Later experimental work revealed that orchietomy or estrogens stopped the functioning of isolated prostates in dogs. Also, it was found that androgens produced metaplasia in dog prostates resembling cancer and that estrogens reversed the effect.⁴ The mechanism of action is not known and the relationship of androgens and estrogens is not fully understood, but they appear to have a fundamental role in cellular physiology. Androgens are controlled by pituitary gonadotropins and estrogens counteract them by inhibiting the production of gonadotropin. However, there may be a direct antagonism at the end organ (prostate), also.

The obvious clinical application of these observations was the treatment of carcinoma of prostate by castration, and this therapy

has been singularly successful.^{1, 4} In most cases there is dramatic relief of pain and improvement in the general condition of the patient. Soft tissue lesions, both primary and metastatic, regress, and occasionally bony metastases show healing. The acid phosphatase drops toward normal and the alkaline phosphatase first rises and then falls, suggesting osteoblastic activity. Although adenocarcinoma responds the best and anaplastic carcinoma the poorest, exacerbation or refractoriness always develops in both types after a variable period of months or years. Because the urinary excretion of 17 ketosteroids first falls after castration and then increases with relapses, it is thought that the exacerbations result from increased adrenal production of androgens in response to a rise in pituitary elaboration of gonadotropin. Estrogens can inhibit this process by impairing gonadotropin production but by the time exacerbations occur they usually have no effect. However, there is disagreement in regard to the use of castration with or without estrogens in the treatment of prostatic carcinoma.

Estrogens alone have had a beneficial effect in prostatic carcinoma with metastases.⁴ Improvement is slower, but is equal to or greater than that of castration. Relapses usually develop in 7-8 months and side effects include nausea, edema, impotence, gynecomastia and muscle pain.

The sex hormones have a place in the treatment of female and male breast cancer, also.^{1, 4, 5, 6} When pregnancy and lactation were noted to cause rapid advance in breast cancer, a mode of treatment was suggested. Later, it was found that the incidence of spontaneous cancer in mice decreased after castration or the administration of androgens, and increased after estrogens were given. Clinically, the response to these substances has not been so clear cut. Androgens cause a transient improvement in the pain of bony metastases in 50% and the alkaline phosphatase rises, suggesting healing of bone lesions, but there is usually no X-ray evidence of improvement. Castration has its best application in premenopausal women, causing relief of pain and general improvement in 15-30% of the cases. This relatively low figure may result from incomplete castration produced by irradiation, the method usually used. Estro-

gens, oddly enough, cause a transient improvement in about 50%; soft tissue lesions both primary and metastatic regress and bone pain is occasionally relieved. On the other hand, they tend to stimulate the cancer in menstruating women, and therefore, are indicated only in radio-resistant tumors at least 5 years after the menopause.

Male breast cancer, likewise, has responded favorably to hormone therapy.⁶ Castration produces healing of bony metastases, especially, and of soft tissue lesions to a lesser extent. The best response is in men over 60 years of age, in contrast to the response in women with the breast cancer, and similar to that in patients with prostatic carcinoma. Patients survive in much more comfort for as long as they do after radical surgery, but reactivation of the tumors develops sooner or later. Stilbesterol has no effect on these exacerbations, which may result from adrenal secretion of androgens. In an attempt to control this process destruction of the pituitary has been suggested and because irradiation of the gland has been inadequate, surgical excision is being considered.

The use of ACTH and Cortisone in cancer was suggested by several observations.⁷ It was noted that adrenal cortical hyperfunction in Cushing's syndrome was associated with loss of body protoplasm and in animals with involution of normal lymphoid tissue. Further, compound E in mice, caused regression of lymphoid tumors. Lastly, the excretion of urinary steroids in cancer patients indicated a possible alteration in adrenal cortical function. Accordingly, ACTH and Cortisone were used clinically and were found to cause progressive decrease in the size of lymph nodes and spleens in chronic lymphatic leukemia, follicular lymphosarcoma and Hodgkin's disease. No effect was seen in prostatic or breast carcinoma.

Carbamates attracted attention as possible cancericidal agents when botanists observed that phenylurethane and some of its derivatives arrested mitoses in the cells of certain plants.¹ Further evidence of their possible value was the retarding effect of urethane on spontaneous breast carcinoma in mice. The mechanism of this action is unknown, but it has been suggested that urethane may compete with the natural enzyme involved in the biosynthesis of nucleoproteins.

Clinically, urethane has produced remissions in chronic myelogenous and lymphatic leucemias and in mycosis fungoides^{1, 8, 9}; altho there has been no increase in longevity of the patients. It has had no effect on other neoplasms except for a possible beneficial action in an occasional case of prostatic carcinoma with metastases.¹⁰ Its adverse effects include severe generalized depression of the bone marrow, albuminuria, hematuria, nausea, vomiting and diarrhea.

Interest in nitrogen mustards (substituted 2-chloroethylamines) developed in World War I when it was noted that mustard gas (dichloroethyl sulfide) caused systemic as well as local toxic reactions in the form of bone marrow depression and leucopenia.¹ Between wars, studies on the nitrogen analogs of mustard gas revealed a cytotoxic action on lymphoid tissue. There apparently is a greater toxicity for rapidly dividing normal cells such as are found in lymphoid tissue, bone marrow, testes, and GI mucosa than for more slowly developing cells of the brain, lungs and kidneys. The site of action probably is in the nucleus because mitosis is arrested at the interphase and in penicillium notatune mutations have been produced.

The over all effect clinically is like that of total body irradiation.¹¹ Of the more than 34 nitrogen mustards that have been tested, methyl-bis (B chloroethyl) amine (HN₂) has been the most satisfactory.^{1, 9, 11, 13} It has had a definite beneficial action in Hodgkin's disease, lymphomas, chronic leucemias, mycosis fungoides, and inoperable anaplastic carcinoma of the lung. Some improvement has been noted in cases of multiple myeloma, neuroblastoma, Ewing's tumor, lymphoepithelioma, and Boeck's sarcoid, but none has been apparent in acute leucemias, squamous cell carcinoma of the lung, carcinoma of the mouth, gastrointestinal and genito-urinary tracts, the nervous system and most sarcomas. Probably its best use has been as an adjuvant to radiation because it seems to make lesions more radiosensitive. The drug is administered intravenously and causes toxic side reactions that may be severe: phlebothrombosis, nausea, vomiting and hemopoietic depression with leucopenia and aplastic anemia. There are many more related alkylamines remaining to be tested and perhaps one will be non-toxic with a specific action on cancer.

The action of nitrogen mustard has stimulated considerable conjecture in regard to the nature of cancer.¹¹ Because their selectivity for some neoplastic cells seems related to the high nucleic acid content of the cancer cells it has been suggested that the cause of cancer may be in the nucleic acid precursor. If this is true, it seems possible that agents capable of producing mutations by their effects on the nucleic acid-containing chromosomes, also, may cause cancer.

The folic acid conjugates, all of which are vitamins, are good examples of the wasted effort that can be caused by misleading information. In the laboratory it was noted that extracts of barley and Brewer's yeast (B complex) and L. Casei fermentation factor (teropterin) caused regression of spontaneous breast carcinoma in mice.¹ How this action takes place is not understood, but it is known that all the conjugates are broken down into folic acid in mammals.¹¹ Unfortunately, clinical trials of diapterin (pteroyldiglutamic acid), teropterin (pteroyltriglutamic acid), and others have failed to show any evidence of their value in cancer therapy.^{1, 3, 9, 11} Furthermore, there is no indication that folic acid deficiency causes cancer.

On the other hand, the folic acid analogs have opened a more promising field of investigation. Farber found that the folic acid conjugates stimulated leucemia and therefore, must be necessary for leucopoiesis.¹ This together with the fact that folic acid deficiency causes anemia and leucopenia suggested the use of antagonists, which seem to act by replacing folic acid in cell metabolism. they cause a depression of bone marrow like that of a folic acid deficiency and this is reversed by giving folic acid.

Aminopterin (4 amino-pteroylglutamic acid) and 2 methopterin (4 amino-N¹⁰-methylglutamic acid), folic acid analogs, and amino-an-fol (4 amino-pteroylaspartic acid) have been tried clinically.^{1, 11, 15, 16, 17} In children with acute leucemias about 52% developed remissions and in adults about 33%. Better results were obtained in lymphatic and subacute leucemias than in monocytic and acute leucemias. Chronic leucemias were not affected. Some improvement was noted in Hodgkin's disease, lymphosarcoma, and neuroblastoma. However, there seems to be no selective toxicity for neoplastic over

normal cells and toxic reactions are severe: stomatitis, pancytopenia, alopecia.

Radioisotopes provide a special method of utilizing irradiation therapy and are considered here because the technics involved are similar to those used with chemical agents.^{2, 18} Radioactive iodine (I^{131}) has been of diagnostic and therapeutic value in the thyroid diseases. Approximately 15% of thyroid tumors concentrate I^{131} and this number is doubled by the use of thyrotropic hormone. Tumors with a regular follicular pattern and containing colloid pick up the material better than solid alveolar or anaplastic carcinomas. If tracer studies indicate that a tumor concentrates I^{131} , it usually will respond favorably to treatment dosages, with regression of the tumor and relief of pain and disability. Carelessness in controlling the amount of irradiation may cause a rapid destruction of functioning thyroid tissue resulting in severe acute hypothyroidism.

Radioactive phosphorus (P^{32}) because it has a selective distribution in hemopoietic tissue showed beneficial effects in polycythemia vera and chronic myelogenous leukemia.¹⁸ Pain was relieved in 10 of 14 cases of multiple myeloma. Administration is difficult because of great variability in the dose required for each patient.

In a colloidal suspension, radioactive gold (Au^{198}) has been given intravenously for treatment of lymphoid-macrophage disease and infiltrated locally into tumors without much success chiefly because the effective distance of irradiation is 2-3 min. However, laboratory studies with a transferrable cancer in rats indicate that it kills the tumor when the two are implanted together in a wound.²⁰ This suggests a possible use in the prevention of cancer implants in surgical wounds after the excision of a tumor.

Bacterial products first attracted attention as possible cancericidal agents in 1868 when Busch reported regressions of sarcomas in two patients coincident with attacks of erysipelas.¹ Later, injection of living streptococcus cultures were found to cause regressions of cancer, and subsequently filtrates of "streptococcus erysipelas" produced degenerative changes in spontaneous dog cancer. Finally, filtrates of *Secretia marcescens* were purified in 1943 and the active principal revealed to be a poly-saccharide. When in-

jected intramuscularly this caused massive necrosis and hemorrhage in mouse cancers, the degeneration stopping at the limits of the tumors. The mechanism of action may be related to the local anaphylactic phenomenon of Arthus in which repeated parenteral injections of a non-toxic foreign protein followed in 10 days to years by a subcutaneous injection of the same protein results in hemorrhage edema and necrosis with sterile abscess formation at the site of injection. The similarity to the Swartzman-Hanger phenomenon is even greater. These men noted that bacterial filtrates injected subcutaneously and followed 4 to 48 hours later by intravenous injection of the same filtrate resulted in hemorrhage and necrosis at the site of original injection. The effect of the filtrates on tumors differs, however, in that a previous sensitization is not required.

The polysaccharide apparently is too crude for clinical use because of marked toxic reactions that occur in the form of fevers to 108 degrees, shock, leucocytosis, and pain in the tumors.^{1, 3} A few fibrosarcomas have regressed markedly, but not enough cases have been treated for adequate evaluation.³ Nevertheless, experimental results indicate that if further fractionation can produce a non-toxic component, it may prove to be a potent carcinolytic principle.

Antireticular cytotoxic serum (ACS) was derived because of observations suggesting that the reticulo-endothelium system has an inhibiting effect on cancer.¹ Proliferation of histiocytes and Kupfer cells in the liver and reticular hyperplasia of the spleen has been noted in experimental tumor bearing animals. Blood from cancerous humans or animals induces splenic hypertrophy in animals. Splenectomy or overloading the R. E. system with colloid in cancer animals stimulates the neoplasm. Lastly, splenic metastases are rare despite the rich blood supply of the spleen and proximity to the GI tract, occurring in only 3.2% of 520 autopsies on cancer patients. On the other hand, liver, lymph node and spleen infiltrations in lymphomas apparently refute a deterrent effect. Furthermore, spleen and tumors can be cultivated together in the same tissue culture medium without effect on either.

On the assumption that cells of mesodermal origin produce stimulating and inhibiting

substances, a serum was prepared by injecting minced rat spleen into rabbits.²¹ The rabbit serum presumably developed antibodies and was designated antireticular cytotoxic serum with the supposed property of stimulating elements of connective tissues, and therefore, possibly activating resistance to cancer. Experimentally, the incidence of virus induced cancer in mice was reduced by this substance, but clinically there has been no evidence of benefit in cancer cases.

Stilbamidine was suggested as a possible cancericidal agent when it was noted to cause a decrease in the elevated plasma globulins of patients being treated for leishmaniasis or kala-azar.¹ Because of this it was tried in cases of multiple myeloma, and after treatment myeloma cells were found to contain inclusion bodies consisting partly of ribase nucleii acid, possibly in an insoluble complex with stilbamidine. The correlation between the elevated globulins of kala-azar and multiple myeloma is only superficial, however, because in the former the gamma fraction is high while in the latter it is the Bence-Jones globulin. Clinically, stilbamidine relieved bone pain in 80% of patients with multiple myeloma but caused permanent toxic degeneration of the sensory nucleus of cranial nerve in two-thirds.^{1, 9}

Viruses are mentioned finally as anti-cancer substances only to discredit them. They were suggested first by the Russians who made favorable reports on their use. Examination of the Russian work by others has showed their conclusions to be invalid and laboratory tests in this country have produced no evidence of benefit in animal cancers treated with a variety of viruses, including those of influenza A, vaccinia, rabies, lymphogranuloma, yellow fever, and herpes simplex.^{22, 23}

In conclusion it can be said that chemotherapy has a definite tho limited application in the treatment of cancer at present. Several agents are specifically indicated in certain conditions: castration or estrogens should be used in prostatic carcinoma with metastases; urethane is useful in chronic myelogenous and lymphatic leukemia when radiation is not possible; and methyl-bis is beneficial in disseminated malignant with or without radiation. A few other substances may be used, tho they are of more questionable value. They

are androgens in breast carcinoma with bony metastases, stilbamidine in multiple myeloma with pain, estrogens in breast carcinoma with soft tissue metastases after the menopause, methyl-bis in inoperable anaplastic lung carcinoma, and radioactive iodine (I^{131}) in certain thyroid carcinomas with metastases. The remaining agents, ACTH and Cortisone, urethane, folic acid conjugates and analogs, polysaccharides, ACS and viruses are not acceptable for general clinical use on the basis of available information at present.

Altho, no cancer cure has resulted from a chemotherapeutic agent, palliation has frequently been marked. Even more important is the knowledge of neoplastic disease that has been derived from the mechanisms of drug action and the responses of neoplasms. There is hope that new and better cancericidal agents will be found among the many remaining to be tested.

BIBLIOGRAPHY

1. Glellhorn, A.: Chemotherapy of Cancer
Am. J. Med. 1949, 6:188-231, #2 (Feb.)
2. Karnofsky, D. A.: Chemotherapy of Cancer
N. Eng. J. Med. 1948, 239:266,260,299
3. Reimann, S. P.: Chemotherapy of Cancer
J. Mich. State Med. Soc. 1949, 48:453
4. McCullagh, E. P.: Sex Hormones in Cancer
Cleveland Clinic Quart. 1949, 16:21-32, #1 (Jan.)
5. Nathanson, I. T.: Hormonal Alteration of Advanced Breast Cancer
Bull. N. Eng. Med. Center 1948, 10:1-5, #1 (Feb.)
6. Traves, N.: Castration in Cancer of Male Breast Cancer N. Y. 1949. 2:191-222, #2 (Mar.)
7. Pearson, O. H., Eliel, L. P.: ACTH and Cortisone in Human Lymphoid Tumors
Cancer N. Y. 1949. 2:943-5, #6 (Nov.)
8. Kennedy, B. J. et al: Urethane in Mycosis Fungoides Cancer N. Y. 1950, 3:66-73, #1 (Jan.)
9. Duffy, B. J.: Chemotherapy of Cancer
Rocky Mt. Med. J. 1949, 46:284
10. Lapidès, J.: Urethane in Prostatic Cancer
Cancer N. Y. 1949, 2:469-74, #3 (May)
11. Rhoads, E. P.: Advances in Cancer Therapy
Bull. N. Y. Acad. Med. 1949, 25:271-84, #5 (May)
12. Landing, B. H. et al: Systemic Pathologic Effects of Nitrogen Mustards
Cancer N. Y. 1949, 1055-66, #6 (Nov.)
13. Burchenal, J. H.: Nitrogen Mustard in Leukemia Cancer N. Y. 1949, 2:1-17, #1 (Jan.)
14. Taylor, S. G.: Terapterin in Far-advanced Carcinomatosis
(Continued on Page 188)

Head Injuries*

ROLAND M. KLEMME, M.D.

St. Louis, Missouri

Morbidity and mortality from head injuries can be reduced materially through early diagnosis. Blood replacement, if indicated, recognition and effective techniques to control hemostasis, debridement of devitalized tissues, appropriate chemotherapeutic agents, and competent nursing care to observe and report any change of condition, are the essential prerequisites.

A careful initial examination and a close observation of the patient in the immediate post-traumatic period are the most important factors in the treatment of head injuries. Shock, if present, is usually easily combated by the use of Saline. Blood or plasma is rarely required. The maintenance of adequate pulmonary ventilation is extremely important. The position of the patient, with his head turned to one side so that the oral secretion will drip out of the mouth, and that the tongue will fall away from the pharynx will obviate intratracheal intubation or tracheotomy in the vast majority of cases. The latter two procedures should be utilized only as last resorts. More than eighty per cent of patients suffering from head injuries will recover with proper therapy. Proper attention to associated conditions may prevent further distressing, and sometimes fatal, complications.

The primary problem in the management of head injuries is the danger from anoxia. Nerve cells can be irreparably damaged when the oxygen supply is limited, even for a very short time. Anoxia of cerebral tissue can occur without visible evidence of cyanosis in other tissues. The amount of damage to the nerve cells is very often definitely influenced by the duration of the presence of intracranial pressure. The greatest damage is not necessarily at the site of impact. Very frequently it is opposite the site of impact and spoken of as contrecoup.

Change in the state of consciousness after

a head injury is of great importance. Of vascular changes, the greatest possibility may be an immediate hemorrhage. The cerebral blood vessels may be ruptured by laceration, or we may have multiple perivascular hemorrhage and edema which is progressive. All cause an increase in the intracranial pressure. These conditions can definitely be evaluated and diagnosed through repeated neurological examination and careful observation. Co-existing traumatic conditions of the body, naturally, should receive proper attention.

TYPES OF HEAD INJURIES

Lacerations and contusions of the scalp and Subgaleal hematomas require as meticulous care as any other injuries about the head. Injuries of the skull may be compound or simple fractures. These in turn may be classified as comminuted or depressed; fracture of the base or vault; and fractures extending into the accessory sinus and mastoid and into major blood vessel channels. Of the injuries to the cerebral tissue, those to be considered of greatest importance are:

(1) An actual swelling of the glia cell, due to trauma, distention of the intracranial vascular system, and an increase in cerebrospinal fluid. All can produce an increased intracranial pressure.

(2) Contusions and lacerations of the cerebral tissue. The former produced by perivascular hemorrhage, the latter by actual rupture of the glia tissue.

(3) Intracranial hemorrhage. The extradural arterial hemorrhage, usually from the middle meningeal artery, is not infrequently associated with primary cerebral damage. This is evidenced most frequently by changes in the state of consciousness. These changes are of great diagnostic importance. The sequence of unconsciousness immediately following trauma, followed by lucid interval, followed by coma, with a rise in blood pressure and a slowing of pulse even without focal signs is quite indicative of an arterial extradural hemorrhage. Treatment of this

* Presented at the Seventieth Annual Meeting of the South Dakota State Medical Association, Aberdeen, S. D., June 6, 1951.

condition is an emergency measure.

(4) Subdural hematomas, on the contrary, due to a dehiscence of the veins entering the major venous sinuses is likely to be very slow progressive syndrome, characterized by dysfunction. This condition most often is confused with intracranial neoplasms, and many times that diagnosis is made, particularly of the subdural type. The most common symptoms are mental dullness or confusion and bizarre neurological signs. Electroencephalography may be of some value, but air studies offer the best diagnostic, as well as localizing sign. Subdural hydrops resembles the dural hemorrhage and the rapidity of formation is almost the same. Occasionally may simulate a middle meningeal hemorrhage. This condition is extremely rare but should be thought of in conjunction with head injuries. Many deaths resulting from intracranial hemorrhage following trauma, if clearly diagnosed, can definitely be prevented. The percentage of deaths from this condition, with proper care and attention, should definitely be reduced. The level of consciousness is highly significant in cerebral damage, and the chronological development is of primary importance.

In our series the period of unconsciousness is definitely related to the prognosis. The longer the period of unconsciousness the graver the prognosis. Respiratory change, particularly the Cheyne-Stokes type, slow, deep, stertorous breathing is indicative of a grave prognosis. Bilateral, fixed, dilated pupils is also an ominous sign. Unequal pupils as a potential localizing sign has not been our experience. Fifty-one per cent of unilateral dilated pupils showed the lesion on the ipsilateral side, forty-nine per cent on the contralateral side. The focal value of unilaterally dilated pupils, we feel, must be disregarded. Absence of reflexes in an unconscious patient portends grave prognosis.

(5) Subarachnoid hemorrhage. The typical clinical picture is that of opisthotonus, neck rigidity, hyperactive deep tendon reflexes, and not infrequently bilateral pyramidal tract signs. The lateralization of damage of the brain is of no importance in this particular condition, as the hemorrhage drains into the cerebrospinal system. Repeated spinal taps against a manometer is helpful. The various types of cranial nerve palsies will be de-

pendent on the radiation of the fracture, particularly those at the base of the skull.

SPECIAL DIAGNOSTIC PROCEDURES

(1) Roentgenologic films should not be contemplated on patients in shock or uncooperative, irrational patients. Most depressed fractures can be diagnosed without x-ray. When patients' condition permits roentgenologic examinations are indicated only for medical-legal purposes.

(2) Spinal puncture is of problematical diagnostic value and associated with some risk. Electroencephalography gives little additional information beyond what is recognized on a careful examination.

(3) Ventriculography is discouraged by many men in acute cases, a dictum that is not borne out by practice. Many intracranial hemorrhages have been diagnosed on our service by early ventriculography. Middle meningeal hemorrhage, subdural hemorrhage and subcortical hemorrhage, which otherwise would have been missed and would have proven fatal, have been diagnosed by ventriculography and treated immediately and successfully. We have no hesitancy in doing ventriculography in acute cases.

Other indications for surgical intervention are lacerations or penetrating wounds, compound and depressed fractures, traumatic arterial venous fistula and spinal fluid fistulae.

Chronic organic lesions following trauma presents an entirely distinct syndrome and is strictly and primarily a psychiatric problem. Briefly, therefore, general management of the treatment of shock, good nursing care, pulmonary ventilation, control of restlessness, prevention of infection, maintenance of good nutrition, occasional active dehydration and surgical intervention when indicated are the principal factors in the care and treatment of head injuries. Most operative procedures on this type of patient are done under local anesthesia, which is far better than subjecting patients to general anesthesia. Restlessness is best allayed by the use of paraldehyde or barbiturates. Morphine should be avoided because it is a medullary depressant. The withdrawal of bloody spinal fluid many times relieves an agitated patient. Antibiotics in otorrhea and rhinorrhea are definitely indicated. The judicious use of a suction apparatus is most helpful from the standpoint of aeration.

Survey of Yankton State Hospital and Redfield State Hospital

* Riley H. Guthrie, M.D., Psychiatrist Chief, Hospital Services Section
Community Services Branch, National Institute of Mental Health
Bethesda, Maryland

The Occasion

A prevailing interest in the State in mental hygiene, mental hospitals and training of psychiatric personnel was found. This is an appropriate time to explore the deficiencies and needs, as well as to enumerate the accomplishments, in the State mental institutions.

Previous Surveys

The report of survey of the Yankton State Hospital by Dr. Samuel W. Hamilton in 1940 was reviewed. Many of his recommendations have been accomplished, but the hospital is still understaffed, has a high rate of turnover of medical staff members, and is still overcrowded.

Administration

Even in a State with a relatively small population it would be advisable to remove the mental institutions from unrelated problems of charity, indigency and penology. The task of planning with State-wide vision for the mental institutions is urgent and becomes inordinate when combined with other responsibilities of the state. (1)

Central administration will have to be developed to accomplish the desired ends such as: a merit system with retirement privileges, better personnel management and selection, review and revision of present methods of collection for maintenance and treatment, a uniform accounting system, revision of the commitment laws, better provisions for the release and aftercare of patients, planning for building programs, establishment of out-patient clinics and improvement of intramural care and treatment. Such accomplishments and improvements depend to a great extent upon the influence of the central department, the funds appropriated and the facilities which are available.

* An abstract of the 107 page report submitted by Doctor Guthrie at the completion of the survey conducted by him between August 21 and 29, 1950. The abstract, with added comments, has been compiled by E. S. Watson, M.D., President of the South Dakota Mental Health Association.

Personnel

The need for a merit system, or State civil service system, is urgent. There are aging employees in the State mental institutions who have no retirement benefits although they have spent several decades in the State service.

Salaries and other inducements differ in the two institutions because of lack of overall, coordinated planning and administration. In both locations there are obvious needs for recreation facilities for employees as well as patients. Both need canteens, recreation centers and better opportunities for amusement of both patients and employees.

SHORTAGE OF PERSONNEL IN ALL CATEGORIES IS RATHER PREVALENT. ADDITIONAL PROFESSIONAL, TECHNICAL AND SKILLED EMPLOYEES ARE ESPECIALLY NEEDED. Educational opportunities for employees, which would be reflected in better care of patients, can be developed only if more well qualified persons are employed to carry out a training program. An adequate supply of physicians and nurses, as well as other professional workers, may not be available for several years; the State authorities should make every effort to encourage education and special training of these most scarce, yet most helpful, employees. The State of South Dakota could well afford to subsidize special training of professional citizens who would be willing to serve in the State mental institutions.

Some factors which encourage good citizens to adopt the State service as a career include: Better working conditions and salaries, promotional opportunities and retirement benefits, educational opportunities, improved living conditions and recreational facilities.

In a large institution, such as the Yankton State Hospital, a capable full-time personnel officer (3), responsible to the Superintendent, could be very helpful in recruitment and selection, maintaining morale and discipline,

in service training and public relations in general.

The hospital now has one staff physician per 272 patients. The medical staff also has responsibility for examination and treatment of 521 annual admissions. The present medical staff of six members should be immediately increased to at least 11 physicians. It is recommended by the American Psychiatric Association (1940-41 standards) that there be, exclusive of the superintendent, one physician for every 200 resident patients, plus one for every 100 admissions, excluding transfers, during the year. On this basis, South Dakota should have had thirteen physicians instead of the six it had at the end of 1949. This would indicate that at least seven new positions should be established. With expansion of facilities and an increase in admissions, more new positions will be needed. It is obvious that the State cannot recruit psychiatrists from its own citizens. It will be necessary to offer additional attractions in order to attract specialists from other states.

There is one ward employee to 9 patients; only 2 of these are registered nurses. The present ward personnel could well be augmented from the present total of 181 to 272 employees. Many more graduate nurses are needed. In 1949 the ratio of patients to total nursing and attendant personnel in South Dakota was 10 to 1 which is second highest in the Division (West North Central Division States, North Dakota, South Dakota, Minnesota, Iowa, Nebraska, Kansas, and Missouri.) This nursing inadequacy is further accentuated by the fact that South Dakota was poorest in the whole Division with respect to the percent that its graduate nurses comprise the total nursing and attendant staff. Only 1.2 percent of this staff in South Dakota are graduate nurses compared, for instance, to Minnesota with a percent of 6.9. In percentage of graduate nurses per 1,000 average daily resident patients in state mental hospitals, in 1948, South Dakota ranked 43rd among the 48 states.

An affiliate training course for student nurses at Yankton would assist in encouraging nurses to return to the mental hospital subsequent to graduation, and attract nurses who are interested in educational programs.

(4)

In-service training of personnel in all cate-

gories would also tend to attract more and better citizens. On-the-job training for attendants in both mental institutions is an extremely important part of a badly needed educational program.

At the Redfield State Hospital, the shortage of personnel and the faulty distribution is similar. The need for additional competent teachers and other skilled and technical personnel is great.

Commitment

The statutes regulating hospitalization of the mentally ill and mentally deficient should be restudied and amended. A proposed model statute for the hospitalization of the mentally ill, together with comments and connotations, has been handed to the Board of Charities. At present commitment to a hospital is confused with incompetency, there are no suitable provisions for the admission of emergency cases, and release of mental defectives is irordinately restricted by the courts. Also, voluntary admission is contingent upon the citizen's ability to pay for care and treatment, to mention only a few of the unsatisfactory statutory provisions.

Building Program

New construction of additional bed space has not kept pace with the increased demand for care and treatment or the growth in the State's population. At the beginning of the decade, overcrowding, dangerous fire hazards and other unsatisfactory conditions existed which have not been corrected.

Some states have provided five mental beds per 1,000 general population. If South Dakota hoped to reach this desired degree of provision of facilities, it would need an additional 1,752 mental beds. Plans should now be made to establish a well designed new mental hospital which should be conveniently located in relation to the State's population.

The waiting list of applicants for admission to the State Home and School, estimated at 600, clearly indicates that additional facilities are needed at Redfield. The unique case-finding program of the State Commission for the Control of the Feeble Minded has resulted in the discovery of many defectives in the state who need either special training or institutional care. (5)

Both immediate and long-term planning with State-wide vision for a building program will require much more time and

thought than can be expected of voluntary groups or of part-time employees.

In 1949 about one-third of the first admissions were for mental diseases of senility and another thirteen percent for schizophrenia. These two groups, accounting for approximately one-half of all first admissions, were composed of patients with relatively low recovery rates.

In planning for future expansion of facilities, much thought should be given to type and functional purposes of additional buildings. It is obvious that the demand for care and treatment of elderly and infirm persons will continue to increase. Facilities for more active treatment programs will be needed, better provisions for group therapy and occupational therapy should be provided, and suitable accommodations for an outpatient clinic at the hospital are desirable.

It is noteworthy that the rate of first admissions in the West North Central Division States is inordinately low, and in no way approaches the expected demand for hospitalization throughout the country, especially in States which have made greatest advances in the care and treatment of the mentally ill.

The accumulation of patients during this period of 19 years has been remarkably small but gradual. It cannot be expected, however, that this small accumulation of patient population will continue if facilities are improved, community services expanded, the general population continues to increase and confidence of the community in the State Hospital continues to grow.

The pressure for beds to accommodate new patients in increasing numbers has probably influenced the State of South Dakota to release patients who have partly recovered and at an earlier stage than is the practice of neighboring states.

Salaries

In 1949 a little over a third (38.3 percent) of all maintenance expenditures in the Yankton State Hospital were for salaries and wages, a figure which probably is reflected in the paucity of professional personnel. It might be mentioned that it is usually considered desirable for a State mental hospital to spend two-thirds of the maintenance dollar for this purpose. It is interesting that at the State School and Home for the Feeble

Minded, about the same percent (40 percent) of total maintenance expenditures was for salaries and wages. (6)

The per capita expenditure in South Dakota for salaries and wages, \$202, is the lowest in the West North Central Division, which has an average of \$286. As mentioned above, South Dakota spends 38.3 percent of its maintenance dollar for salaries and wages. It is the lowest percent of all the seven Division States and should be compared with Minnesota's figure of 60.5 percent, and the Division average of 53.1 percent.

Concerning the maintenance expenditure per patient in State mental hospitals in the United States, by State, in 1948, South Dakota ranked thirty-ninth among the 48 states. (7)

It appears that employment in the State Hospital will have to be made more attractive if the State is to reach a comparable position with its neighboring States.

The Yankton State Hospital

There is no public transportation between the hospital and the city.

On August 20, 1950, there were a total of 1,631 intramural patients. The estimated capacity of the hospital is 1,532 beds. The rated capacity of the hospital is regulated by statute, and the overcrowding is, according to statutory requirements, an emergency situation.

The power house would be unable to supply steam for heating additional buildings.

The hospital has one fire engine and one ladder trailer. There are fifteen voluntary firemen who live on the hospital grounds, and are paid ten dollars per month extra for their services. There are no fire drills for patients or employees and there is no fire alarm system. Extinguishers are placed in most of the buildings, especially in the kitchens. The city fire department responds when called. All buildings are fire resistant or fire proof, but there are several fire hazards which include the rear center building, "M" building, "H" building, and the oldest structure, the administration building with two wings.

There are some large dormitories, one with sixty-nine beds, but most of the buildings have small dormitories and single rooms. Bathrooms, water closets and lavatories are not adequate in most cases, especially in the wards which are most overcrowded. The required number of these utilities should be

more closely studied in planning for future needs.

Many refrigerators are located on wards and more are needed.

The laundry is fairly adequate, although some new equipment is needed. Present space and equipment will not accommodate enlargement or expansion of the hospital.

The old chapel and assembly hall is a fire hazard and is now used only as a recreation center.

A dairy herd, produces 3,200 pound of milk daily, which is adequate for the patients, after being supplemented by dried milk in cookings.

Dr. Donald B. Williams is assistant Superintendent, and he also performs the duties of Clinical Director. There has never been a position of clinical director provided for the hospital.

The organization of the medical staff is not satisfactory; first, because of the large turnover of physicians during the past decade, and second, because of the absence of a full-time clinical director. The turnover has been great and every effort has apparently been made to recruit additional physicians. Fortunately, the State Board of Medical Examiners permits physicians to be employed at the hospital who are not licensed in South Dakota, so long as they do not participate in private practice.

Examining rooms are located on each receiving ward "H" building and "Pierce" building in conjunction with emergency rooms. Most of the other wards do not have regular examining rooms.

Progress notes, apparently, are kept up to date in spite of the shortage of staff, although these notes are often cursory.

The X-ray department is in charge of a technician who is also responsible for the pharmacy and for the physiotherapy work. The X-ray equipment is old, but includes a stereoscope and a fluoroscope. Major surgery is sent to the Sacred Heart Hospital. Operating room space and equipment at the State Hospital is not satisfactory. Patients who need refraction are also sent to the city to the consultant's office. It would be much more convenient if arrangements could be made for the ophthalmologist to do his eye surgery and refraction in the State hospital.

The superintendent and assistant superin-

tendent are used as consultants in the community. They are on the staff of the Sacred Heart Hospital in Yankton which has recently developed a small psychiatric ward. There is no training of undergraduates, and the clinical material is not used for medical instruction although three medical students are spending the summer at the hospital.

Only two registered nurses are employed.

The impression is gained that persons employed on the ward's services are well meaning, but untrained and unskilled in the proper care and treatment of patients and in the psychiatric attitude toward their patients. For example, restraint is used too freely, and without due consideration for the patient's welfare.

The superintendent is aware of the need to improve nursing care and is cooperating with nurse officials in the state to establish affiliation in psychiatric nursing for student nurses from general hospital schools. (8)

Before students may be admitted, qualified graduate nurse personnel needs to be employed for sufficient time to enable them to:

- (a) instruct the attendant personnel in approved psychiatric procedures.
- (b) organize clinical services to which students may be assigned.
- (c) prepare curriculum for the student nurses.
- (d) plan for their acceptance with the nursing directors of the general hospital schools.

In addition to the graduate nurses personnel, there will be need to plan for lectures, clinics and demonstrations by psychiatrists, occupational therapists, social workers, psychologists and others.

Transportation to the city will be needed as it is not available now and appropriate residence with acceptable supervision are prerequisites.

There is a beauty parlor in the basement of "Lee" building, which is in charge of a beautician. There are two chairs, driers, and considerable assistance is given by patients. This function could be improved and expanded considerably to the benefit of women patients.

Employee's quarters are not satisfactory, although the new employee's building, which houses seventy-four employees, is a great improvement. Many of these quarters are un-

satisfactory, and some are on wards where patients also are located. Free care and treatment is offered to employees who become ill, but accommodations are poor since only one room on the men's receiving and another room on the women's receiving ward are available.

The dietary department is in charge of an unregistered dietician who is known as the matron. She also supervises all domestic employees, including the main offices. The cooks, baker, butcher and dining room personnel are directly under her supervision.

Food is apparently adequate and, on the whole, wholesome. Milk is on the table at each meal. Thermos carts are used to convey food to the outlying dining rooms and wards. The tray service, especially on the wards for the aged and infirm, is not very satisfactory, and the food is often cool.

The organization of the receiving services, as indeed the organization of the clinical and nursing services throughout the hospital, is not satisfactory. This is due in a large part to the shortage of competent physicians and registered nurses.

The criminal insane and violent men patients are located on "15-C" where there is considerable crowding. Tuberculous patients are cared for on the porch of "M-1" where ambulatory tuberculous patients are permitted to mix considerably with other patients. Here twenty-four men tuberculous patients are cared for, twenty of whom are bed patients. The women tuberculous patients are cared for on "Pierce-3" where many arrested and senile patients are also located. There are fifty-one women patients on this ward, many of whom, no doubt, are unaffected or arrested cases. No registered nurse is employed on either of the wards for tuberculous patients. (9)

Overcrowding is most obvious on the wards for disturbed patients and for senile and infirm patients. Here the need for more space and better care is most obvious.

Considerable physiotherapy equipment is available, but can be used only two hours each day because the technician also is responsible for the X-ray and pharmacy departments. He is experienced, but not a registered technician. No electrocardiograph or electroencephalogram is available. Hydrotherapy has never been used at this hospital.

Six thousand dollars has been appropriated and is available to establish a department of hydrotherapy. A supplementary appropriation will be necessary before the equipment can be purchased and installed.

Industrial therapy shops include a sewing room with two employees and eight patients, a mending room with two employees and eight patients and an arts and crafts room with one employee and six patients. All these activities should be the responsibility of the registered occupational therapist. The therapeutic attitude would then be more prevalent.

A canteen for the convenience of both patients and employees is needed.

Individual or group psychotherapy cannot be undertaken with the present limited staff.

Restraint is used to freely on some wards. Restraint and seclusion are used only upon written order of the ward physician, but patients are often tied to benches without this authorization. Statistics concerning the number of hours and number of patients in both restraint and seclusion are needed. These facts would focus more attention of employees upon the practice.

The patients library of about 2150 books is operated by a fulltime employee. Better reading space is needed and ward employees should be encouraged to bring more patients to the library.

There is no provision in the statute for emergency care and treatment of mental patients, and the regulation of hospitalization of the mentally ill in the State should be carefully restudied.

There is no provision for aftercare of patients in the community. No social worker is employed at the hospital. No outpatient clinics are conducted by the hospital staff. The State of South Dakota makes no provisions for family care or boarding of patients.

Provisions for the care and treatment of the mentally ill have not kept up with the demands made upon the hospital.

Among the future needs of the hospital are: a building for tuberculous patients, replacement of the East Wing of the Administration Building, replacement of the West Wing of the Administration Building, and remodeling of a portion of the West Wing of the Administration building. The "Jayne" Building, which was built in 1945, should be completed

by installing the elevator and the lighting fixtures. Plans should be made also to erect a chapel, to enlarge and equip the storeroom or warehouse, to remodel and enlarge the shops, to enlarge and equip the laundry, and to remodel the "Barracks" building. An occupational therapy building, which might include a recreation center for patients and employees, a patient's library and the various industrial therapies should be built in the near future.

The method of accounting and bookkeeping at the hospital should be restudied. The purchased provisions during the past year amounted to \$.37 per day per capita, and this is, no doubt, increasing. It is not possible to determine, according to present records, the actual per capita cost for food because of the farm production and the government surplus which are not properly evaluated.

Since there is no public transportation from the hospital to the city, better facilities for recreation for employees should be provided. Only fifty-eight employees now live off the hospital campus. In spite of recent increases in salaries, it is difficult to attract suitable personnel without more attractive accommodations and living conditions, as well as working conditions.

Redfield State Hospital

Other states release more patients to extramural care without formal discharge.

The commitment statutes and the rigid regulations of the release of patients in South Dakota discourage trial visits of patients, which many states consider to be a valuable aid in the process of rehabilitation.

Slightly less than 40 percent of all maintenance expenditures in the institution went for salaries and wages. It is considerably lower than the desired proportion which is customarily expected to be spent for this item.

Iowa has almost 5 times the average daily population of South Dakota. However, when we compare the expenditures for salaries and wages the ratio is almost 8 to 1.

Comparing annual per capita expenditures for maintenance in institutions for mental defectives in each of the West North Central Division states in 1949, South Dakota is second lowest, \$1.16 per patient per day. It is the lowest in per capita expenditures for salaries and wages.

The rated capacity of the institution is 690 beds while on August 26, 1950, there was a total of 740 patients. Six hundred are now on the waiting list for admission.

The first building constructed in 1901 is of native granite and is now used as an employee's home. There are no fire escapes on this building which is three stories high.

Electricity is manufactured but the engines and generators are overloaded. A new engine and generator is needed in addition to the two in use. Much new equipment is needed, including coal handling machinery at the power plant and an additional boiler will be necessary especially if expansion of the institution is planned.

Fire protection is rather poor at the institution. There is a one man-drawn cart with hoses. No fire drills are held. Very few fire extinguishers were seen in the ward buildings and there is no organization for fire fighting. None of the three story buildings has fire escapes, although some have wood floors. The employees' farm cottage, where 16 employees live, has been condemned and is a fire hazard.

Some of the dormitories contain as many as 95 beds. Bathroom and water closet facilities are inadequate in most every location.

Two ward buildings have not been screened against flies.

The laundry is located adjacent to the power house, very near the cinder discharge, and the location is entirely unsuited. The building is too small and new machinery is needed.

The clinical records and case study methods are quite unsatisfactory. No regular progress notes are written. Physical examinations are done at irregular intervals, perhaps only when the patient is physically ill.

The X-ray equipment is quite old and there are exposed wires leading from the tube to the stand. The X-ray and fluoroscopic equipment seems to be dangerous.

There is no physical therapy department. There is no dental X-ray.

There is no registered dietitian. There are three general kitchens, and one diet kitchen in the hospital building. Considerable additional equipment is needed in all locations.

At present the total ward personnel is 41, including 2 matrons giving the ratio of one ward employee to 18 patients. Attendants re-

ceive a salary of from \$85 to \$120 per month. This is a smaller salary than the farm hands receive. Most of the attendants are elderly or middle-aged people who are not active but are thought to be kind to the children. The ward employees are untrained, and although kind to the patients, are not skilled in the care and training of patients.

Considerable interest has been shown in the sterilization of the mentally deficient in South Dakota and 764 patients have been sterilized since the procedure was authorized by statute. During the past year, however, only one patient has been sterilized.

The daily per capita cost in 1948-49 was \$1.16.

During the fiscal year 1950 the per capita cost per day is \$1.55.

Improvements which are needed and should be provided by the next session of the Legislature (10) include an employees building which would house about 125, additions to the boiler and power house including a new boiler, engine, generator and coal handling equipment, a new laundry and additional equipment, a warehouse and equipment, remodeling of wards No. 1, No. 2, and No. 3, a physical therapy department, a school building, a girls ward building for about 185 patients, a building for 150 epileptic patients, a boys ward building for approximately 185 patients, a new greenhouse, remodeling of Granite building and installation of elevator, remodeling of the service building to include tile floors and new ceilings, the installation of an elevator and bathrooms in the administration building, additional hog barns and chicken houses, a superintendent's home and a roof on a wing of the cow barn. In addition to these, new X-ray equipment is badly needed, and a dental X-ray should be provided. New dishwashers should be provided for all kitchens throughout the institution and additional toilet and lavatory facilities are needed on most wards.

General Recommendations

1. Central administration of the State's mental institutions in a full-time State agency should be provided. This should insure better coordination, long term planning with State-wide vision and better administration practices.

2. The commitment laws should be re-studied and amended. Release of patients

from both mental institutions is too rigidly controlled and restricted by statute.

3. Methods of collection for care and maintenance should be altered, and general accounting procedures should be improved and made uniform.

4. A merit system, or State civil service, should be inaugurated, and greater efforts will be necessary in attracting and retaining well qualified citizens as employees.

5. In-service or on-the-job training should be given to employees in all categories. The state could well afford to subsidize specialized training of capable professional personnel who are now so scarce in the State's mental institutions.

6. The establishment of educational programs in the State Hospital is urgent, and should include:

- (a) Accredited training of psychiatric residents.
- (b) Education in psychiatric nursing by affiliation.
- (c) Graduate educational program for nurses.
- (d) Training courses for attendants with due recognition for progress.

7. All ward personnel and nursing activities should be under the general supervision of a director of nursing services who should have two assistants, one administrative and the other educational.

8. Additions to the medical staff are urgent. There should be both a clinical director and an assistant superintendent at Yankton.

9. A graduate and experienced dietician should be responsible for the preparation and service of food in both locations.

10. Expansion of the following departments in both institutions is urgently needed:

- (a) Clinical psychology.
- (b) Psychiatric social work.
- (c) Occupational therapy.

11. Selected volunteer workers might be helpful, if given proper orientation. Red Cross workers or other volunteers should be recruited.

12. Adjunct treatment programs should be developed further, such as: physical education, music recreation, physical therapy and bibliotherapy.

13. Individual psychotherapy, group therapy and other active treatment programs should be expanded as the number and com-

petency of the medical staff members permit.

14. Family care, or boarding-out, of patients should be developed; this system might serve to decrease some of the present overcrowding.

15. A coordinated building program with State-wide vision should be inaugurated. Both the immediate needs and long-term planning should be studied carefully.

16. State planning should include a new mental hospital located conveniently with relation to the distribution of the general population.

17. Community or outpatient clinics should be established by staff members of both institutions. Their effectiveness will depend upon the recruitment of additional trained psychiatrists, clinical psychologists and psychiatric social workers.

18. General hospitals within the State should be encouraged to build and operate psychiatric units or wards.

The general recommendations are by no means inclusive and no attempt has been made to rate them according to priority. Immediate emphasis should be placed on the relief of overcrowding, recruitment and training of additional, suitable personnel, and acceleration and expansion of the treatment program.

COMMENTS

By E. S. Watson, M.D.

At the conclusion of his survey in August, 1950, Dr. Guthrie appeared personally before the State Board of Charities and Corrections, and gave them his oral report of the survey and his recommendations. These recommendations were transmitted by the Board of Charities and Corrections to Governor George Mikkelson and the Budget Board and were considered in the preparation of the budgets of the Yankton State Hospital and the Redfield State Hospital for the biennium beginning July 1, 1951. The final written report was available by the time the Joint Appropriations Committee of the House and Senate considered the appropriations for the institutions and the information contained in the report was transmitted to the Committee by the Board of Charities and Corrections.

Administration

The administration of the Yankton State Hospital, the Redfield State Hospital, the State Training School at Plankinton, and the

State Penitentiary at Sioux Falls, is in the hands of the Board of Charities and Corrections. This is a three man board, appointed by the governor. The board functions part time, and visits each of the institutions once a month. It is called into extra session on occasion to consider special business relative to the institutions.

Dr. Guthrie points out that "the task of planning with state-wide vision for the mental institutions is urgent and becomes inordinate when combined with other responsibilities of the State." He goes on to recommend "central administration of the state's institutions in a full-time agency." Many states have such full-time central administration of its mental hospitals. The state of Minnesota is said to have a model mental health administration. In the state of Minnesota, a governmental Department of Social Security was organized in 1939. The Department of Social Security consists of a Director of the Division of Public Institutions, a Director of the Division of Social Welfare, and a Director of the Division of Employment and Security. The Director of the Division of Public Institutions oversees the management and planning of the state's mental hospitals, the state hospitals for the mentally retarded and epileptic, the schools for the deaf and blind, the school for crippled children, the training schools and penal and correctional institutions. On his staff is a psychiatrist who holds the title of Commissioner of Mental Health. The management of the mental institutions is under his jurisdiction.

Prior to the establishment of the Division of Public Institutions in 1939, the management of state mental institutions was vested in the State Board of Control. This board was abolished, and its powers and duties were transferred to the Division of Public Institutions.

Personnel

Early in his report, Dr. Guthrie stresses the shortage of personnel in the Yankton and Redfield institutions. It is well known that personnel, properly trained and adequate in numbers, is much more important in the treatment of mental patients than fine buildings and elaborate equipment. In this respect, there is striking contrast between the state hospital at Yankton and the Veterans Administration Neuro-psychiatric Hospital at

Fort Meade. The latter has plain buildings, but adequate staff. All of the psychiatrists on the staff are certified, and certified, qualified personnel are to be found in all departments, including occupational therapy, recreational therapy, hydrotherapy, and social service work. Part of the answer to this situation is to be found in the fact that the wage scale from psychiatrist to attendant at Fort Meade is nearly double the wage scale at Yankton. Since we must go outside of the state to hire properly trained personnel, we need to offer a higher wage scale than is prevalent in those states where training centers exist.

Dr. Guthrie recommends that there should be a "capable, full-time personnel officer" at Yankton. Since the report was made, the office of Personnel Officer has been created and filled. The efficient conduct of this office will depend, in large measure, upon the training and experience of the officer in mental hospital personnel problems.

In mentioning the paucity of graduate nurses on the staffs of the Yankton and Redfield institutions, Dr. Guthrie notes that South Dakota makes the poorest showing in this respect of the seven states in the West North Central Division, and that we rank 43rd among the 48 states with respect to nurse-attendant ratio. Since the survey, money was appropriated by the last legislature for the establishment of a nursing affiliate program at Yankton State Hospital, and plans are going forward with the prospect that the nursing program may be underway sometime during the fall of 1951. In his report to the State Board of Charities and Corrections for the biennium ending June 30, 1950, Dr. Hogan made this statement relative to the nursing situation at the Redfield State Hospital. "Our one graduate nurse was forced to resign. We have been unable to secure the services of a graduate nurse since her resignation." Since this statement was made, however, one graduate nurse was secured. The nursing situation at Redfield is better understood when it is realized that the staff performs a considerable number of major surgical operations and that there are constantly a considerable number of bed patients in the infirmary.

Building Program

In commenting upon the need for more

buildings at Redfield, Dr. Guthrie points out that there is a waiting list of approximately 600 for admission to the Redfield State Hospital. The State Commission for the Control of the Feeble-minded has identified approximately 8,500 mentally retarded individuals throughout the state. Except for the 760 institutionalized cases at the Redfield State Hospital, the state is doing nothing in an organized way toward the education and rehabilitation of these unfortunate people.

Salaries

The survey shows that only 38c of the maintenance dollar at Yankton is being spent for salaries and only 40c of the maintenance dollar at Redfield is being spent for salaries, whereas "it is usually considered desirable for a state mental hospital to spend 66c of the maintenance dollar for this purpose." In 1947-48, Dr. Guthrie points out, South Dakota ranked 39th among the 48 states in maintenance expenditure per patient. The research staff of the Council of State Governments reported that South Dakota ranked 45th among the 48 states in maintenance expenditure per patient in the fiscal year 1948-49.

These facts were before the Budget Board, the Governor and the last legislature. Still, appropriations for the next biennium are too meager to allow for substantial improvement in maintenance. For example, at Yankton an estimated \$1.70 for patient maintenance per day will be available during the next biennium as contrasted to the present figure of \$1.54. This slight increase may be nullified by rising costs.

Yankton State Hospital

Of the special needs listed by Doctor Guthrie, the last legislature provided appropriations only for the erection of a new tuberculosis building, remodeling of the west wing of the Administration Building, and repairs for the Industrial Building and Barracks Building.

Redfield State Hospital

In listing the special needs, Doctor Guthrie places an Employee's Building at the head of the list. In his report to the State Board of Charities and Corrections for the biennium ending June 30, 1950, Doctor H. W. Hogan headed his recommendations with an appeal for an employee's building, saying, "The

(Continued on Page 188)

PRESIDENT'S PAGE

D. A. Gregory, M.D.

JULY MESSAGE

It is a grand honor to be President of the South Dakota State Medical Association and I accept it with pride and a great amount of humility.

I am following an active President who has literary ability, as shown by his President's page. He is interested in the improvement of the Association and I hope that he will continue to serve us. Our secretary-treasurer, Dr. Mayer, has had a long and useful service to the profession and has been elevated to the Vice Presidency.

By this time the committee members have been notified of their appointments, these are important assignments and the committee's have definite duties; PLEASE do not wait until next year to have a meeting and organize. The reports of committee's are essential for the information of the House of Delegates who are the legislative body of our Association.

The District officers should meet and arrange a schedule of the meetings to be held. The scientific program should be arranged so that it will be interesting as well as informative. In the smaller districts the meetings can be consolidated with larger districts and if the members do not care to write papers, speakers can be imported. We have competent men in our state who will take time to come to your meetings. Motion pictures are easily and inexpensively obtained and projection machines are easily borrowed. The films are usually 8 or 16 mm. and some require sound apparatus. Nearly every high school has a good projection machine. I urgently request that the District Societies select and elect delegates who can and will attend the meetings, they are the spokesman of their Districts and should know the will and pleasure of their Districts.

The State officers are only the executives and are to carry out the directives given them by the House of Delegates and the Council. An active secretary of the District is a jewel of great value, it is a necessary position and most of the work of the District is usually shoved off on him. Please help him and show your appreciation of his service by paying your dues promptly, it is discouraging for a secretary to be a collection agency; he becomes discouraged and should be encouraged and given a word of appreciation. The younger men in the district should be encouraged to take an active part in the meetings.

We have some men in active practice in this state who are not members of the District societies, they should, if eligible, be urged to join. In union there is strength. You may not like a competitor but competition makes improvement. Most of us are individualists but we should not be feudists. We are not Hatfields and McCoys and should not be shooting at one another. I believe some noted minister after seeing a drunkard fall in the gutter said, "there, but for the grace of God, go I."

I have preached enough. My 35th class reunion was held at Vanderbilt University and was glad to attend without a wheel chair or cane. Perhaps the Black Hills District will hold a summer meeting and invite me, then I can take another vacation. Wishing all of you a pleasant and restful summer and may our relationship for the coming year be one of mutual benefit.



EDITORIAL PAGE

ANNUAL MEETING 1952

The 71st Annual Meeting of the Medical Association will be held in Sioux Falls, in May 1952. The exact dates haven't been selected as yet.

One of the most difficult jobs in setting up the meeting is the selection of speakers. Our meeting in Aberdeen showed excellent choice by our program committee who evidently had excellent advice from individual association members.

And, of course, that's what we're putting ourselves into print now. Our program committee needs your advice on speakers for the 1952 annual meeting. Please make your suggestions to D. A. Gregory, M.D., Milbank; Roy E. Jernstrom, M.D., Rapid City; L. J. Pan-kow, M.D., Sioux Falls, or to the executive office.

For Long Service

Rewards for serving the medical profession are of an intangible nature. Therefore, when one has served for many years and then decides to slow down to get the utmost enjoyment out of life, he expects no more reward than the intangibles mentioned above.

Now and then, however, the Journal has an opportunity to say "thanks" to such a person. Our thanks, on behalf of the medical profession, is directed to Dr. C. E. Sherwood of Madison, who leaves next month to take up residence in Indiana.

Dr. Sherwood served the profession for many years as a member of the State Board of Health. Later he became a member of the Board of Medical and Osteopathic Examiners and acted as its secretary. He was secretary of the South Dakota State Medical Association for six years and served as the medical member of Selective Service's Board of Appeals.

The contribution to medicine in South Dakota made by Dr. Sherwood cannot well be estimated at this time. But to him — our thanks!

GULLIBLE'S TRAVELS

Wednesday, May 30 — Packed **Helen Sundstrom** and **Dorothy Alguire**, two-thirds of the office staff, into the car and drove to Aberdeen so they could set the wheels turning for the Annual Meeting. Then I drove across Minnesota and into Wisconsin by midnight.

Arrived in Whitehall, Wisconsin the next morning where I was to give the commencement address for the local high school. Spoke that evening to a crowd of 900 jammed into the school gymnasium and then spent a few hours with **Dr. Simon Ivers** who is a member of the school board and a most accomplished host.

June 1 — Drove back to Aberdeen in time for dinner and a quick perusal of the status of annual meeting plans. Everything in readiness, we proceed to

June 2 — Business sessions, exhibit booths, hotel reservations, guest speakers etc.

June 3 — House of Delegates, committees, more exhibitors, stag party. 'Nuff said.

June 4-5-6 — The happy daze of confusion that culminates in a quick trip home and an opportunity to sit down and relax until

The next morning when wife, kids, and **Gullible** left for Northern Michigan to give the family a rest. Gullible drove on to Atlantic City to attend the AMA sessions and the meeting of the medical society executives conference.

Arrived in Atlantic City Sunday night just in time to miss a meeting of the Conference of Presidents and other Medical Society Officers. A cloudburst in Youngstown, Ohio did the dirty work.

Monday June 11, attended the MSEC where **M. C. Smith**, my colleague from Nebraska did a fine job in a discussion session.

On Tuesday, I visited the exhibit hall, sat in on the House Meetings and watched the presidential inauguration that night when **Dr. John Cline** accepted his office.

Wednesday — rain, no game.

Thursday, June 14 — left Atlantic City early in the morning and drove all the way to Saginaw, Michigan before running down. Visited there with a cousin and then pro-

ceded to northern Michigan to reclaim my family. (Have I told you about my new daughter?)

Arrived in Sioux Falls late Monday night June 18.

June 20 — held a conference with **Dr. Einar Andressen** who handles medical matters for the V.A. over a wide midwest area and with **Paul Dickensheets** of the local office. Most enlightening.

DIABETES KITS NOW AVAILABLE

The U. S. Public Health Service, Federal Security Agency, today announced the availability of a kit of audio-visual materials for patient education in diabetes. The kit is intended for use by physicians, nurses, dietitians and other professional workers engaged in the instruction of diabetic patients.

Surgeon General Leonard A. Scheele of the Public Health Service pointed out that adequate health education of persons with diabetes has long been a problem in many communities.

"Diabetic patients must necessarily develop some specific skills and acquire certain health habits if they are to live comfortably with their ailment," Dr. Scheele said. "It is our hope that this kit of materials will make it easier to teach diabetic patients the whys and hows of insulin treatment, diet control, and other important aspects of the disease."

The kit is available for purchase and, in some instances, for loan. It was prepared co-operatively by three national agencies specifically concerned with the welfare of the diabetic: the American Diabetes Association, Inc., the Diabetes Section of the Public Health Service, and the American Dietetic Association. It has the endorsement of the American Nurses Association.

The kit, which requires the use of a 33-1/3 rpm record player and a 35 mm. film projector, covers all the important things a diabetic should know about taking care of himself. It contains:

- 11 colored filmstrips
- 11 phonograph records
- 1 "Guide for Instructors"

1 "Diabetes Guide Book"

1 "Meal Planning with Exchange Lists"

1 set of booklets for patients

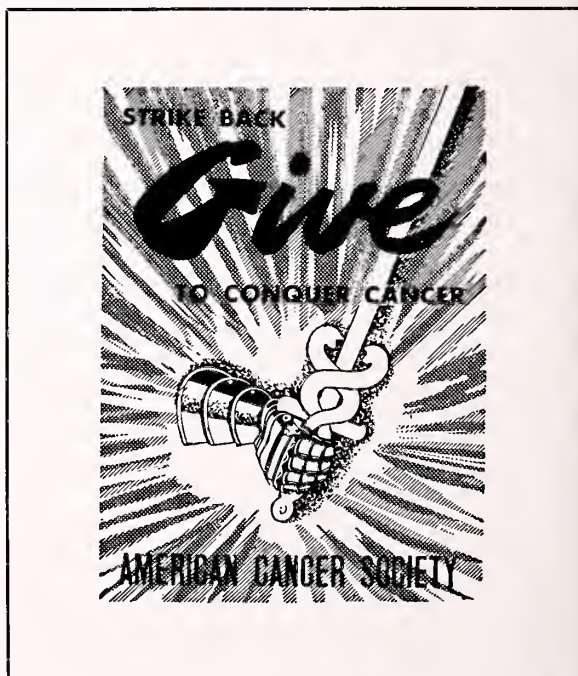
12 colored wall charts

The materials are developed around the story of a typical new diabetic patient. How the patient finds out about his condition, how he learns to take his insulin, how he learns about meal plans are some of the episodes unfolded in the six medical nursing and five nutrition filmstrips.

The manual of instruction ("Guide for Instructors") is based on actual experience in teaching groups of diabetics. It includes suggestions for organizing and conducting a series of classes and individual film guides (lesson plans) for all eleven films.

Complete kits may be purchased from Health Publications Institute, Inc., 216 N. Dawson Street, Raleigh, North Carolina. Full information about the kit, its price, packaging and use, may be obtained directly from that organization.

Persons wishing to obtain the kit solely for preview may borrow it from their State health departments. Those wishing kits for short-term loan may get them from Film Library, Communicable Disease Center, Public Health Service, Atlanta, Georgia.



This is



JULY
1951

Vol. 4 No. 7

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Thirty-One Medical Students Begin USD Preceptorships

Thirty-one second year students at the University of South Dakota School of Medicine will serve one month as clinical clerks with doctors in South Dakota starting June 25.

This is the third year these clerkships have been offered the sophomore medical students at the end of his work at the University. The program has met with success the two previous years and the word received from the students is that it has been very beneficial in their advanced work. Because of the fine achievement thus far, several medical schools have adopted a similar plan patterned after the program of the University School of Medicine.

Serving the University will be doctors in all parts of the state who will act as preceptors in working with the sophomore medics. The clerkships will last through July 20 and end in time for the students to prepare for entering four-year schools of medicine in the fall for their junior and senior years.

This year's class of thirty-one is the largest ever sent

out for advanced work and the largest group to enter into the clerkship training.

Students, their preceptor-doctors, and the respective towns: Richard Adams, Dr. Brown, Brown Rousseau Clinic, Watertown; Robert Bell, Dr. Peeke, Volga; Sterling Bell, Dr. Dawley, Rapid City; Frank Boyd, Dr. Saxton, Huron Clinic, Huron; Robert Brunken, The Drs. Price, Armour; David Buchanan, Dr. Younker, Sisseton; Michael Donley, Dr. Erickson, Sioux Falls; Kenneth Dregseth, Dr. Schwartz, Wakonda; Bernard Gerber, Dr. Scallin, Redfield; Edward Gerber, Dr. Hamm, Sturgis; David Goodman, Dr. Austin, Brookings Clinic, Brookings; Phyllis Huffman, Dr. Davidson, Lead; Walter Judge, Dr. Duncan, Peabody Clinic, Webster; Muriel Lamkee, Dr. Hubner, Yankton; Arthur Larson, Drs. Gregory, Judge, Milbank; Gene Lewallen, Dr. Dean, Wessington Springs; Sherman Lindell, Dr. McVay, Yankton Clinic, Yankton; John Myers, Dr. Reding, Marion; Phillip Ostlund, Dr. Whitson, Madison Community Hospital, Madison; Alvin

Peterson, Dr. Lloyd, Mitchell; Charles Reynolds, Dr. Spiry, Mobridge; Earl Rose, Dr. Quinn, Burke; James Scallin, Dr. McVay, Yankton Clinic, Yankton; Keith Sehner, Dr. Ted Holm, Holm-Tschetter Clinic, Huron; Jewel Severson, Dr. Howe, Deadwood; George Shaw, Dr. Drobinsky, Estelline; Lincoln Solberg, Dr. Delaney, Sr., Delaney Clinic, Mitchell; Clifford Tschetter, Dr. Graham, Chamberlain; Kermit Vandenbos, Dr. Williams, Rapid City Medical Center, Rapid City; Shirley Van Ferney, Dr. Saxton, Huron; Donald Weatherill, Dr. Sebring, Martin.

VERMILLION YOUTH WINS SCHOLARSHIP

Lincoln Solberg, Vermillion, a second year medical student at the University of South Dakota, has been awarded the Christian Peter Lommen scholarship.

The Lommen award is made each year to a second year student on the basis of scholarship, need for financial aid and character. This scholarship is a gift to the University Medical School from Prof. Raybor Greenleaf Wellington.

NEW OFFICERS TAKE ASSOCIATION POSTS

A new slate of officers took over operation of South Dakota State Medical Association affairs after elections at the 70th Annual Meeting in Aberdeen. **Dr. D. A. Gregory**, Milbank became president, **Dr. Roy E. Jernstrom**, Rapid City moved up to president-elect, and **Dr. R. G. Mayer** of Aberdeen became the new vice-president. **Dr. L. J. Pan-kow** of Sioux Falls was named secretary-treasurer and **Dr. A. P. Peeke** replaces **Dr. H. Russell Brown** as Speaker of the House of Delegates.

Two new councillors, **Drs. R. A. Buchanan**, Huron, and **Magni Davidson**, Brookings, were named to replace **Doctors B. T. Lenz** and **G. E. Whitson**.

DELEGATES SHUFFLED AT DISTRICT MEETING

The Third District Medical Society met at Martinson's Tea Room in Volga to hear a presentation by **Dr. E. S. Watson** of Brookings and to appoint replacements for the House of Delegates vacancies created at the recent Annual Meeting.

Replacing **Dr. M. Davidson**, who became a councillor, is **Dr. Dean Austin**. **Dr. Harold Wold** replaces **Dr. C. E. Sherwood** who is leaving the State. Named as alternate delegates were: **Drs. Robert Henry** and **J. A. Muggly**.

Dr. E. S. Watson, president of the South Dakota Mental Health Association presented

an abstract of **Dr. Guthrie's** survey of the Yankton and Redfield State institutions with his own comments.

A discussion followed on the problems of the mental institutions.

The auxiliary met at the home of **Mrs. A. P. Peeke**. The next meeting was scheduled for Brookings.

"FIGHT FOR LIFE" TO START 3rd YEAR

The radio series "Fight For Life" which completed its second year is now planning to begin its' third this Fall. Starting on KUSD in Vermillion the program was carried last year by four stations. Plans for next year call for the same coverage.

Although the Medical Association participated in 1950 and not in 1951, proposals are now being studied for the coming year.

Dr. John Rodine of Aberdeen is chairman of the Association' Radio Broadcast Committee.

LILLY CREATES NEW BLOOD CENTER

Because stock-piling of human blood plasma for military or civilian disaster is considered an essential defense measure, **Eli Lilly and Company** has announced plans to establish a modern blood-processing unit. Over 2,000,000 pints of blood were processed and supplied at cost by the Lilly company during World War II. The new unit, to be set up and operated in Indianapolis for the Armed Services Medical Procurement Agency of the

United States, will be completed late this year.

Whole blood collected in principal Midwestern cities by the Red Cross will be expressed to the Lilly plant in refrigerated containers. Almost immediately after the whole blood arrives, processing starts with the centrifugation of plasma from the cells. The plasma is drawn off, pooled, and irradiated with ultraviolet light. The latter step has been added since World War II and is designed to inactivate the virus responsible for hepatitis. The plasma is then shell-frozen against the inside surface of a rotating bottle. Drying is accomplished by controlled temperature and high vacuum. Rigid aseptic technics are followed in processing, and all plasma must pass sterility tests. Plasma will be packaged in a sealed moisture-proof container with a companion bottle of sterile diluent. Sterile tubing and hypodermic needles will complete the unit, which will provide ready-to-administer plasma at the scene of injury.

NEWS NOTES

The meeting of the State Board of Medical and Osteopathic Examiners was held in Rapid City July 17-18 for the first time in that location in many years.

* * *

Dr. C. E. Sherwood, secretary of the Examining Board has resigned his position as of August 1. He will move to Indiana.

* * *

Drs. John L. Calene and

Donald L. Kegaries attended the American Heart Association meeting in Atlantic City last month. **Dr. Kegaries** is president of the South Dakota Heart Association.

* * *

The South Dakota Selective Service office had to fill a quota of two M.D.'s in July. This is the first call other than the services recalling reserve officers.

* * *

Dr. A. P. Reding of Marion has been appointed as the medical member of the Selective Service Appeal Board which meets periodically in Mitchell. He replaces **Dr. C. E. Sherwood**.

* * *

Dr. Magni Davidson of Brookings has been recommended to fill the unexpired term of **Dr. C. E. Sherwood** on the Board of Medical and Osteopathic Examiners.

* * *

South Dakota's A.M.A. delegate, **Dr. H. Russell Brown** of Watertown is the chairman of the A.M.A.'s House Credentials Committee.

* * *

Warren L. Jones, M.D. has established practice in the Sioux Falls Clinic Building. **Dr. Jones** is a member of the Milwaukee County Medical Society and the Wisconsin Medical Society.

CONVENTION SIDELIGHTS

A year ago at Huron, two scheduled films didn't show up for annual meeting show-

ings. This year, due to an overzealous office staff, two prints of one film put in an appearance at Aberdeen.

* * *

Too much floor space worked against a good play for the exhibitors.

* * *

This meeting produced what was undoubtedly the smoothest operating House of Delegates sessions in history. Much credit is due the speaker, **Dr. H. Russell Brown**, and the committee chairmen who prepared their reports well in advance.

* * *

Much credit for a smooth-sailing program of business is due the overworked secretary, **Helen Sundstrom**, who compiles all the notes. This was her second convention with the organization.

* * *

This years convention produced the best-equipped auditorium to assist our exhibitor friends. **Fred Sully** and **Frank Wytttenbach** were most cooperative.

* * *

Aberdeen physicians did a nice job on local arrangements—Orchids to **Dr. P. V. McCarthy**, general chairman.

* * *

Audrey Strandt was the organist who made the excellent music for the banquet.

* * *

Dr. Wm. Baker, speaker on the program, arrived at 3:30 one morning to find his room occupied by another **Bill Baker**. This type of coincidence is extremely hard on the nervous systems of executive-secretaries.

I. C. S. CHICAGO MEETING SET FOR SEPTEMBER

The International College of Surgeons will hold its sixteenth annual meeting at the Palmer House in Chicago September 10-14, 1951.

For information, write to **Dr. Arnold S. Jackson**, Sec'y, 1516 Lake Shore Drive, Chicago 10, Illinois.

U. S. VITAMIN BUYS ARLINGTON

The U. S. Vitamin Corporation, New York, has announced the purchase of the Arlington Chemical Company of Yonkers. Plans call for an enlargement of the facilities of both organizations. Arlington has pioneered in the introduction of many highly regarded ethical products since its inception in 1877.

Many new products are planned for the new facilities with all Arlington personnel continuing in their positions.

Address of the main offices remains 250 E. 43rd St., New York 17, New York.

HEART ASSOCIATION SETS NEW PROGRAM

In announcing the appointment of **Dr. Victor Lorber** of Cleveland, Ohio, as its first Career Investigator, the American Heart Association today became the first voluntary agency to undertake a program providing for continuing careers of scientific research investigators of proved ability and originality.

Dr. Lorber, Associate Professor of Biochemistry at Western Reserve University, will receive a starting annual stipend of \$12,000 to conduct research relating to disorders of the heart and blood vessels. It is the intention of the Association to continue this support throughout the productive life of the Investigator.

In making the announcement, Dr. Louis N. Katz, President of the American Heart Association, pointed out that the Association has established this first of a series of Career Investigatorships as an important phase of its overall national research program. This new type of research support, which has long been advocated by leading scientists in this country, makes it possible for investigators to devote life-long careers to medical research.

The Career Investigator, Dr. Katz said, is free to engage in research of his own choosing. He may work in any institution in the United States which offers adequate facilities. In addition to his annual stipend, a maximum of \$7,500 per year is made available to the Investigator for technical assistance and supplies. The institution where he chooses to work will receive \$1,000 annually for overhead.

MENTAL HEALTH ASS'N NEWSLETTER QUOTES MED. ASS'N, ERRS

The May-June newsletter of the South Dakota Mental Health Association carried a statement that the Medical Association approved the use

of unlicensed physicians in state institutions if they were supervised by licensed physicians.

Upon investigation, the Mental Health Ass'n president indicates that the story should have read "the State Board of Medical & Osteopathic Examiners" rather than the Medical Ass'n.

MEDICAL WRITERS TO MEET IN PEORIA

The 8th Annual Meeting, American Medical Writers' Assn, will be held at the Pere Marquette Hotel, Peoria, Ill., afternoon and evening of Wednesday, Sept. 19, 1951, during 16th Annual Meeting, Mississippi Valley Medical Society (Sept. 19, 20, 21) at the same hotel. The program will consist of presentations by Dr. Ralph H. Major of Kansas City, Kansas, Prof. of Medicine and of the History of Medicine, University of Kansas; Dr. Austin Smith, Editor of the Journal of the American Medical Association; and Miss Marquerite Stadelhofer, St. Louis, Managing Editor, the C. V. Mosby Co., Medical Publishers. A new constitution, which somewhat liberalizes membership requirements, but does not alter the present educational requirements, will be voted on. There will be NO REGISTRATION FEE and all ethical physicians and others who are college graduates, who are interested in medical writing or journalism, are cordially invited to attend. A program of the meeting may be secured from the Secretary, Harold Swanberg, M.D., 209-224 W.C.U. Bldg., Quincy, Ill.

MISSISSIPPI VALLEY MEDICS TO MEET

The 16th Annual Meeting of the Mississippi Valley Medical Society will be held at the Pere Marquette Hotel, Peoria, Ill., Sept. 19, 20, 21, 1951, under the Presidency of Dr. Ralph McReynolds of Quincy, Ill. Over 30 clinical teachers from the leading medical schools will conduct this great post-graduate assembly whose entire program is planned to appeal to general practitioners. There will be over 50 scientific and technical exhibits, noon round-table luncheons, etc. NO REGISTRATION FEE will be charged and every ethical physician is cordially invited and urged to attend. The entire program and all exhibits will be held in the Pere Marquette Hotel. A program of the meeting may be obtained from Harold Swanberg, M.D., Secretary, 209-224 W.C.U. Bldg., Quincy, Ill.

CHEST PHYSICIANS ELECT OFFICERS

The 17th Annual Meeting of the American College of Chest Physicians was held at the Ambassador Hotel, Atlantic City, New Jersey, June 7 through 10, with a registration of 1040. On Saturday, June 9, at the administrative session, the new officers were elected for the coming year.

Dr. Chevalier L. Jackson, Philadelphia, Pennsylvania, was named president.

At the Convocation ceremony held on Saturday, June 9, 109 physicians received their Fellowship Certificates. Oral and written examinations for Fellowship in the College were given to 58 physicians on Thursday, June 7.

PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor

Newer Therapeutic Agents

by Edgar Parry, Instructor in Pharmacy

South Dakota State College

The Physiological Activity of ACTH and Cortisone:

The most familiar of the effects of Cortisone therapy is the antiarthritic effect. Case histories in which Cortisone or ACTH has completely reversed the course of rheumatoid arthritis are common. These drugs relieve the ache and pain of motion, reduce the swellings, and joint function and activity reappear. Muscle strength is regained; flexion deformities, bursitis, and enlarged lymph nodes disappear. Only those deformities caused by cartilage, bone and ligament calcification remain. In the vast majority of cases the patient resumes his normal life, free of pain, but dependent on Cortisone to keep his life that way.

How do these drugs accomplish this? At present there are only a few theories to explain their action. One of the more acceptable is concerned with the relationship of arthritis and the enzyme Hyaluronidase, sometimes referred to as the spreading factor. When injected under the skin, it dissolves the intercellular matrix, and allows all cells free access to any fluids then injected. The inflammation of joints in arthritis could be due to excessive loss of hyaluronic acid, a carbohydrate in matrix, through the action of hyaluronidase with an accompanying abnormal calcification resulting in constant irritation of the synovial membranes when joints are moved. Cortisone inhibits hyaluronidase, thereby stopping the breakdown of the matrix. Some researchers think Cortisone may be responsible through its nutritional effect, for the production of matrix. These, and other theories, remain to be proven. Any explanation for the action responsible for the antiarthritic effect must remain questionable since so little is known of the causative factors

in rheumatoid arthritis. The action, whatever it may be, is thought to be responsible for such other collagen diseases as exfoliative dermatitis and rheumatic fever.

The second effect of these drugs is termed the nutritional effect. The patient receiving either of these drugs experiences an increase in appetite and a gain in strength. Cortisone is fundamentally a metabolic hormone, active in the conversions of ingested protein and carbohydrate to usable and necessary body carbohydrates. Therapeutic administration of either of these hormones results in an increased glycogen deposition in the liver and a higher blood sugar level. Many patients are forced to take insulin for the first time and diabetics find their requirements for insulin are greater. So active is the metabolic activity of Cortisone in breaking down protein and amino acids, that a nitrogen deficiency and negative nitrogen balance may result. Ordinarily this is offset by the increased intake of food and a high protein diet.

An interesting phenomenon is the Cortisone-insulin synergism. The same antiarthritic effect can be obtained from 50 mg. of Cortisone with 40 units of insulin as is produced from the normal 100 mg. dose of Cortisone alone. In explaining this synergism, it is assumed that Cortisone acts catalytically in the synthesis of specific carbohydrates (perhaps the hyaluronic acid of cell matrix,) and insulin increases its activity by making activation products of glucose available from sources other than amino acids. Any hypoglycemia resulting can be easily controlled. The advantages of this synergism are quite apparent — by halving the Cortisone dose we double its availability or number of doses, cut the cost per dose, and greatly

reduce the side effects from Cortisone.

A predominantly beneficial psychic effect is also produced by ACTH and Cortisone. There is an increased sense of well being, a euphoria with increased mental energy. Some of this effect is no doubt due to release from pain and to nutritional changes. The loss or lessening of symptoms brings hope, but there is also definite action on the cerebrum. The patient's ability to think and to concentrate are stimulated. This stimulation of cerebral facilities is quite severe in some cases, resulting in insomnia, definite swings of mood and various psychoses. The more serious of these is thought to occur only in those patients who have a tendency toward psychoses. Dosage must be reduced promptly in these patients. So definite is the action of these substances in changing the brain wave pattern, that ACTH is being given experimentally to persons suffering from schizophrenia in hopes it may shock the wave pattern back to normal. Thus far, the results are inconclusive.

These drugs show a definite effect on the electrolyte system, both result in retention of sodium and water with an accompanying loss of potassium and chloride ions. This hypokalemia may result in serious alkalosis. It shows up readily in E C G readings, and in such symptoms as weakness and hypotension. Dosage should be lowered and a sodium restricted diet instituted. Diuretics of the mercurial type may be given, but cautiously. Many doctors give from two to four grams of KCl daily as a preventive measure.

ACTH is a more constant offender in this side effect than in Cortisone. It stimulates production of Desoxycorticosterone along with Cortisone. Since both of these cortical hormones cause the retention of sodium, ACTH should have twice the effect in this direction as Cortisone alone.

A biochemical effect resulting in increased hemoglobin and erythrocyte count has not been explained. Trials have been made in the various anemias without very much success.

The effect on wound healing is controversial. Although it has been shown definitely that ACTH and Cortisone inhibit fibroplasia in laboratory animals, their effect on human wounds have not been established and further evaluation is necessary before declaring them safe to use during and after surgery. How-

ever, they are very effective in controlling the acute lesions of ocular diseases which are in the inflammatory and exudative phases. They hasten the healing of lesions that have been one of the chief causes of blindness because of their difficulty to control. Hereditary and degenerative eye diseases do not respond, nor do they affect the basic cause of the lesions — tuberculosis, syphilis, or infection. Antibiotics should be given simultaneously for these.

The effect of an excess of either of these results in the condition known as Cushing's Syndrome — hirsutism, rounding of the face, acne, amenorrhea, etc. This is reversible and clears up on withdrawal. Cortisone suppresses the anterior pituitary and causes reduction in size and activity of the adrenal cortex. Oddly enough, Cortisone, a secondary hormone, suppresses the pituitary more than the primary hormone ACTH. This suppression, along with adrenal stimulation or Cortisone therapy results, is responsible for these changes.

One last accountable action is that which occurs in bronchial asthma and hypersensitivities. One hundred mg. of Cortisone per day for one or two weeks is usually sufficient for an entire hay fever season. This remarkable antihistaminic action is thought to be due to inhibiting the formation of histamine rather than preventing the histamine from reaching the tissues — the action of regular antihistamines.

Because of the many and varied responses of the body to these two hormones, and because of our limited knowledge of the vital roles the newer hormones play in everyday life, it is impossible to account for many of the effects we know they produce. By more trials and experimental work an answer to these problems will be found and a wider knowledge of human physiology will be evolved. Only then will doctors be able to foretell which patient will suffer relapse, and to what extent side effects will curtail the use and benefits in any patient.

A brief resume of the usefulness of these drugs would break them down into the following general categories. These diseases in which a permanent or prolonged remission occurs includes rheumatic fever, the hay fever — bronchial asthma group, exfoliative dermatitis, and acute ocular inflammation. A

group which responds favorably, but relapses on discontinuing the drugs, include rheumatoid arthritis, psoriasis, ulcerative colitis, lymphosarcoma and hemolytic jaundice. A number of conditions are under investigation where the action is not uniform, but the results favorable enough to warrant further investigation. In this group, ACTH therapy in schizophrenia is inconclusive. Both hormones appear to hasten recovery in acute alcoholism and delirium tremens. Myasthenia gravis is improved in some cases, in others it is aggravated. Cortisone has cured typhus fever in some unknown manner, but it not constant.

In several diseases it is known to be detrimental. Cortisone increases gastric pepsin and causes perforation in gastric and duodenal ulcers. It is contraindicated in tuberculosis. It is responsible for the spread of this disease. It has been suggested that Cortisone might be used along with Streptomycin to drive the bacilli out into the blood stream so Streptomycin can kill them. The hormones can be used in diabetes mellitus, but the increased glycosuria must be controlled with increased insulin. Their tendency to retain water and sodium contraindicates their use in congestive heart failure and hypertensive cardiovascular disease. Although Cortisone seldom increases blood pressure, ACTH often does as a result of increasing peripheral arteriolar resistance. This may be due to impurities in ACTH. They shouldn't be used in osteomalacia since both increase fecal excretion of calcium.

Although the actions of these hormones are unknown, their effects are so dramatic, demand has far exceeded supply. The Merck Company is building a second plant and expects to double its output in 1952. They have also pooled their patents with Ciba and Schering.

An effort is being made to synthesize a portion of the ACTH molecule. This hormone is a protein made up of amino acids whose total molecular weight is about 20,000. It is peculiar in that heat and acid do not destroy its biologic activity — in fact they seem to enhance the adrenal cortex stimulating activity. Also, peptide fragments of the ACTH molecule made by hydrolizing it, retain the biologic activity of the parent hormone and

have proved active against arthritis. These peptides are made up of an average of eight amino acids with a molecular weight of about 1200. Whereas there is no hope of synthesizing a heavy molecule such as ACTH, several laboratories are at work trying to synthesize these peptides. Such a peptide would mean increased supply and a purer substance with fewer side effects.

Whether ACTH and Cortisone are the end products in the search for an antiarthritic drug is questionable, but they have opened the way for a new type of therapy against a group of heretofore incurable diseases.

CONVENTION NOTES

The Sixty Fifth Annual Convention of the S. D. Pharmaceutical Association was held at Watertown on June 12, 13 and 14th. The attendance was better than average, but was still short of the number that should attend the annual convention, Lets do better next year.

The local pharmacists under the chairmanship of **Loran Thomes** had an excellent program arranged for both the druggists and their families. A Smorgasbord luncheon, golf and trap shoot, theatre party, bridge luncheon and banquet and dance and the travelers mixer party were on the entertainment side of the program.

On the serious side, the general sessions held at the Elks club included a group of outstanding speakers on professional pharmacy, merchandising, veterinary products and general business affairs. Talks were given by **L. J. Pankow, M.D.**, Sioux Falls; **W. L. Mickelson**, Walgreen Co.; **Dr. John Ehrlich**, Park-Davis; **Dr. H. C. Batson**, U. of Illinois; **J. C. Sheve**, Lederle; **T. W. Reul, M.D.**, Watertown; **Roy L. Sanford, A.Ph.A.**; **Benj. A. Smith**, Eli Lilly; and **Malcolm Solberg, O.P.S.** Most of these talks will be printed in later issues of the Journal.

Albert O. Bittner was chosen as President of the Association for the next year. Other officers are **J. C. Shirley**, Brookings, 1st Vice-president; **Neil Fuller**, Chamberlain, 2nd Vice-President; **Chas. VanDeWalle**, Sioux Falls, 3rd Vice-president; **E. W. Peterson**, Elk Point, 4th Vice-president; **Frank Bockhoven**, Clark, Treasurer; and **Bliss Wilson**, Pierre, Secretary.

The Association recommended to the Governor that one of the following be named to the Board of Pharmacy; **Ted Hustad**, Wall; **Harold Mills**, Rapid City; or **L. J. Mowell**, Murdo. The man appointed will replace **M. C. Beckers**, Rapid City at the expiration of his term.

The 1952 convention city will be Rapid City. Here is a chance for the "east river" druggists to convention and vacation at the same time. Start planning now to be there. Tentative date is some time in May.

Pharmacy Examinations were conducted by the Board on June 5-6-7. A list of the successful candidates will be published in the next issue of the Journal.

Robert G. Fisk, State College of Pharmacy '40 received his M.D. degree at the University of Illinois, Chicago in June, 1951 and starts his internship at St. Elizabeth Hospital, Chicago, July 1st.

Quentin G. Fisk, State College of Pharmacy '41 received his M.D., degree at the University in June 1950, has served a year internship at Elmhurst Memorial Hospital and starts a 3 year fellowship at the Hines VA Hospital, Chicago, July 1st.

NEW ARMOUR ARGENTINE PLANT WILL CUT WORLD INSULIN SHORTAGE

Armour and Company of Chicago will shortly open a new plant in Buenos Aires, Argentina, to tap new sources of raw material to relieve a potential shortage of insulin and increase supplies of ACTH and trypsin, F. W. Spuecht, president, announced today.

The plant, a new 70,000 square foot, four-story, fully air-conditioned building (1473-87 Calle Cevallos) is now being equipped with North American machinery, while a staff nucleus is being recruited here to train the Argentine personnel who will eventually operate the establishment.

The plant's production will go first to supply the needs of Argentina. The Argentine government has agreed to permit the export of the surplus. It is estimated that about 20 per cent of the potential capacity for these three drugs will be required to fill all Argentine needs, leaving 80 per cent for world-wide distribution.

"The opening of the new plant will be especially significant to those who recall what happened in early 1942, just after the United

States entered World War II," Mr. Specht said.

"The world shortage of insulin that broke then was a warning. Within the last few months, moreover, representatives from Norway, Denmark, Germany, Switzerland and Belgium have called on The Armour Laboratories with pleas for more insulin material.

"They recall the days of 1943, when thousands of French and other European diabetics died because there was no insulin, and the efforts Armour and other sources here made to supply England after the bombings had destroyed factories and refrigeration facilities. At one time England had only a few days' supply.

"During the 'black market' days of 1946 when animals were diverted from legitimate meat packers, many of the raw pancreas glands were lost and a critical shortage of insulin threatened. If this happened again, the situation would be much more acute because the demand for insulin has practically doubled since 1946."

The amount of insulin the world uses, Mr. Specht said, has been doubling every six years, because the use of insulin may keep patients alive for a normal span of life. New cases are constantly being added. Moreover, recent diabetes surveys have uncovered thousands more previously unsuspected cases, while the consciousness of the disease aroused by such studies continues to produce still more.

"Under the circumstances," Mr. Specht said, "Armour has turned to the Argentine, a great livestock-producing country, where we already have Armour establishments and where, we find, large quantities of fresh pancreas for insulin and Tryptar and pituitary glands for Acthar can be made available to fill the ever-growing need."

Mr. Specht said the Argentine development also anticipates increased demand for Acthar, the company's brand of ACTH, and Tryptar, its brand of crystalline trypsin.

Acthar was made available to medicine by Armour chemists nearly four years ago for research and within the last year for general medical use. Its power to control arthritis, rheumatic fever, allergy, asthma and other difficult conditions has been well established and it is likely that many other diseases will be added to the list. The Armour Labora-

tories is still the only important supplier.

Tryptar is a highly purified form of an enzyme produced by the pancreas, the natural function of which is to break down protein foods in the digestive tract. Only recently, however, it has been found useful in dissolving away dead tissue in disease conditions such as tuberculous empyema and in badly lacerated, infected or gangrenous wounds, leaving them sterile and clear of debris. It does not affect living tissue and thus has the power to perform a sort of chemical dissection in wounds. It is still in the research stage, but the results so far have been so striking The Armour Laboratories expect a substantial demand for it eventually from both civilian and military surgeons.

T. E. Hicks, vice-president in charge of Armour and Company pharmaceutical operations said that the Armour subsidiary responsible for the new plant will be known as Laboratories Armour d Argentina, S.A. It will be headed by S. B. Bradshaw, Ph.C., F.C.S., president, who is also manager of the international department of The Armour Laboratories, with Loyal C. Maxwell as vice-president and J. G. Speer as secretary and treasurer.

NEW HEMATINIC FOR HYPOCHROMIC ANEMIA

Lakeside Laboratories announces the introduction of Ferrophyll, the new hematinic for rapid and sustained therapeutic response in hypochromic or secondary anemias. Containing exsiccated ferrous sulfate 200 mg., sodium potassium copper chlorophyllin 25 mg. and vitamin B12 2 mcg., Ferrophyll Tablets accelerate blood regeneration and are especially valuable in acute anemia secondary to chronic hemorrhage.

The pyrrol rings of chlorophyll, structurally similar to the non-protein portion of hemoglobin, are thought to be utilizable by the body in hemoglobin formation. Studies have indicated more rapid hemoglobin regeneration when chlorophyll was combined with iron therapy.

The copper in Ferrophyll is present in the optimal proportion for facilitating utilization of iron. The vitamin B12 is included for its known value in stimulating showers of hemoglobin stocked reticulocytes when iron is

present.

Available in bottles of 50 tablets, Ferrophyll is administered in a dosage of one tablet three times daily.


ARMOUR COMPANY STARTS NEW PLANT

Ground was broken for the new Armour Pharmaceutical Center in Kankakee County, Illinois, June 21, and it was revealed that the Company hopes to begin operations there within 18 months.

The plant is being built on a mile-long, 175-acre tract just north of Bradley, Ill. The initial construction will consist of 11 buildings of modern design.

F. W. Specht, president of Armour and Company, and T. E. Hicks, vice-president in charge of The Armour Laboratories, officiated at the ground-breaking ceremonies. They pointed out that The Armour Laboratories have outgrown their present manufacturing facilities in Chicago, and that the increased demand for Acthar, insulin and other pharmaceuticals has made it necessary to set up new manufacturing facilities as soon as possible.

**AMERICA'S AUTHENTIC
HEALTH
MAGAZINE**



*For
Greater
Understanding
of Your
Work*

*today's
health*

In Your Waiting Room

3 YEARS \$6.50
2 YEARS \$5.00
1 YEAR \$3.00

AMERICAN MEDICAL ASSOCIATION



From where I sit by Joe Marsh

"One For The Book"

Miss Reynolds, our town librarian, really put a smart-aleck motorist in his place last week—happened right in center of town, at the corner of Main and Walnut.

Her car stalled, tying up traffic. Most drivers just waited quietly—realizing she couldn't help it—but one fellow kept blaring away on his horn.

So Miss Reynolds gets out of her car, walks over and says sweetly, "I'm afraid I can't start my engine. But if you'd like to try I'll stay here and lean on that horn for you." That stopped him—cold!

From where I sit, a lot of us are sometimes overeager to "sound off" before we really understand what it's all about. Like those who would tell a man where and how he should practice his profession . . . like others who would deny their neighbors the right to a glass of beer now and then. It's a good idea to get a true picture of the situation before blasting out at anyone who "gets in the way" of our own pet ideas!

Joe Marsh

(Continued from Page 175)

problem of securing enough employees properly deserves paramount consideration. There is a very pressing need for many more attendants." Yet he has no place to house more employees. In the face of this critical employee situation, the Governor and the Budget Board denied the request for an employee's building. The legislature appropriated funds for an Epileptic's Building and completion of a new Ward Building, but made no provision for the housing of the new employees needed to care for the increased patient load. None of the other recommendations made by Doctor Guthrie were carried out by the last legislature.

Purpose

The purpose of the foregoing abstract and comments has not been to criticize any individual or group or institution head. The institution heads are deserving of commendation for carrying on remarkably well and conscientiously under great financial handicap. On the whole, the State Administration is responsive to the demands of the public. If we, the public, voice our demands for better salaries, trained personnel, modern equipment and adequate buildings, then — and only then — will our mental patients receive adequate care. We will have to decry governmental economy at the expense of substandard treatment of the mentally ill.

(Continued from Page 164)

- J. Lab. & Clin. Med. 1948, 33:1641, #12 (Dec.)
15. Thierseh, J. B.: Bone Marrow Changes and Tumor Remissions from Aminopterin Cancer N. Y. 1949, 2:877-83, #5 (Sept.)
16. Dameshek, Wm.: Folic Acid Antagonists in Leukemia Blood 1949, 4:168-171 #2 (Feb.)
17. Jacobson, W.: Antifolic Acid Agents in Acute Leukemias J. Lab. & Clin. Med. 1948, 33:1641, #12 (Dec.)
18. Brown, B. R.: Radioactive P³² in Treatment of Blood Dyscrasias Bull. N. Eng. Med. Center 1948, 10:185-191, #4 (Aug.)
19. Hahn, P. F.: Au¹⁹⁸ in Cancer Am. J. Med. 1949, 7:243, #2 (Aug.)
20. Clarke, T. H., Hohf, R. P.: Unpublished experiments
21. Herman, J.: ACS Cancer N. Y. 1949, 2:329-40, #2 (Mar.)
22. Moore, Alice: Effect of Viruses on Mouse Tumors Cancer N. Y. 1949, 2:516-34, #3 (May)
23. Cutting, W. C.: Antiviral Agents in Cancer Therapy Stanford Med. Bull. 1949, 7:161-164, #4 (Mar.)

PRESIDENT'S PAGE

D. A. Gregory, M.D.

AUGUST MESSAGE

A VACATION — DOCTOR?



Most of us rush frantically through a vacation, we drive as far as possible, as fast as possible, and return home exhausted to get on the treadmill. We have only so many days and must return on schedule, probably to die on schedule, or often ahead of schedule. The rush and hurry of our lives is carried over into our vacations, because "leisure" is an absent factor in our present mode of living. Reports, committees, drives, campaigns, radio, television, and clubs allow little or none. We seem to have lost the art of relaxation and peaceful contentment; and the vacation, which was meant to cure, may instead tax to the uttermost an already overburdened physique. Yet no trip, no absence from office routine, or daily labor can be honestly termed a "vacation" unless it has restored to us that physical and mental poise of which we are conscious when we feel most 'fit.'

I open old Noah's dictionary and find two definitions of vacation that interest me.

First: VACATION—the act of vacationing; a making void or of no force; as the vacation of an office or of a charter.

Second: VACATION—the intermission of a stated employment, procedure, or office; a period of intermission, rest, leisure.

Both of these definitions impose conditions which qualify a vacation. The first emphatically states that we must step out of ourselves, free ourselves from those irritations to which we are daily subjected. There must be "a sweeping out" of the mind to make way for its refreshment and re-creation. Body relaxation automatically follows and the vacationist is ready to renew himself—ready to restore his "vim, vigor, and vitality." Yet the average physician in the conduct of his life is apt to attain this "act of vacating, this making void or of no force" only by a permanent passing from the scene instead of the implied temporary release from it. (see the rate of coronary deaths in J. A. M. — **it is high.**) Another type of vacation has been beautifully described by Dr. Alvarez in the "**Second Symposium: The Clinical Problems of Advancing Years.**" "**The Little Strokes**" should be read by all of us and especially by the younger men in our profession. Possibly "The Little Strokes" follow or are accelerated by our lack of a true vacation: a course of action that affords us "rest" or "leisure."

With the second definition all of us are more familiar. "Time off" has a welcome sound but it should not be merely a period of intermission. It should also be one of rest, and leisure, in order to fulfill its function. Professional people as a class, and the medical profession in particular, have a tendency to ignore the latter part of this vacation prescription.

Some of us take a business holiday, we visit clinics, take special courses, and investigate new methods. The lectures we attend may not furnish new ideas. They may simply resurrect old ones almost forgotten; but, they do stimulate us and they do encourage us in the constantly needed pursuance of knowledge. They give us a feeling of the satisfaction that follows the confirmation of our own opinions by others. We gain in assurance, and are suddenly aware of the practical worth of Emerson's sage advice, "Trust thyself—every heart vibrates to that iron string."*

(PRESIDENT'S PAGE Continued)

There is undisputed value in this sort of 'time off' but to recondition ourselves properly we need more than this freshening of professional attitudes. We need to consider ourselves as persons and human beings. We enjoy the escape from the telephone, and the meetings with old friends which we weave around the professional brushing up we do while "on vacation," or perhaps we had better say while "off duty." But we should add to this at least a short period during which we revive ourselves as personalities. Dactor, what gives you the greatest sense of rest? — What gives you a lift in spirit? — Set aside a bit of your vacation to supply these urgent needs of yourself and it will add years to your life and excellence to your service.

Where is the time to take such a vacation? Medical men should help each other to attain it comfortably. The responsibility of the Doctor for his patients' welfare necessitates proper arrangement for their care, in order that he may leave his work with mental ease. The association of two or more men in a group facilitates the taking of a vacation. Older men would profit by having younger men associated with them, and there is mutual benefit from this kind of a partnership. The younger man can learn much of the art of medicine from an older associate, and his wisdom and experience are steadying. The younger man, in turn, contributes new ideas and methods and inspires the best efforts of the older doctor who has the 'know how' of long years of service.

Another thing, don't let the desire for increased income interfere with your needed recreation period. The more you make the more you have to explain to the collector of Internal Revenue. Time is precious. A vacation which achieves its purpose can increase its value. Let us remember with Omar Khayyam that *"The Bird of Time has but a little way to flutter --- and the Bird is on the wing."

* Essay on Self-reliance

*Rubaiyat

Stanza 7

P.S.

Donations to the South Dakota Medical School Endowment Fund are deductible; so before taking that much needed vacation send your contribution to The Endowment Association, Medical Association Office, Sioux Falls, South Dakota.

Transactions of the South Dakota State Medical Association

Seventieth Annual Session

Huron, South Dakota

June 2-6, 1951

OFFICERS, 1951-52

President

D. A. Gregory, M.D. Milbank

President-Elect

Roy E. Jernstrom, M.D. Rapid City

Vice-President

R. G. Mayer, M.D. Aberdeen

Secretary-Treasurer

L. J. Pankow, M.D. Sioux Falls

AMA Delegate

H. Russell Brown, M.D. Watertown

Speaker of the House

A. P. Peeke, M.D. Volga

Alternate Delegate to A. M. A.

William Duncan, M.D. Webster

Chairman of the Council

R. E. VanDemark, M.D. Sioux Falls

COUNCILORS

First District (Aberdeen)

J. D. Alway, M.D. (1953) Aberdeen

Second District (Watertown)

Rodney Stoltz, M.D. (1953) Watertown

Third District (Madison)

Magni Davidson, M.D. (1954) Brookings

Fourth District (Pierre)

M. M. Morrissey, M.D. (1953) Pierre

Fifth District (Huron)

R. A. Buchanan, M.D. (1954) Huron

Sixth District (Mitchell)

F. D. Gillis, M.D. (1954) Mitchell

Seventh District (Sioux Falls)

R. E. VanDemark, M.D. (1954) Sioux Falls

Eighth District (Yankton)

A. P. Reding, M.D. (1953) Marion

Ninth District

A. A. Lampert, M.D. (1952) Rapid City

Tenth District (Rosebud)

R. J. Quinn, M.D. (1952) Burke

Eleventh District (Northwest)

A. W. Spiry, M.D. (1952) Mobridge

Twelfth District (Whetstone Valley)

F. F. Pfister, M.D. (1953) Webster

COMMITTEE APPOINTMENTS

STANDING COMMITTEES — 1951-52

Scientific Work

D. A. Gregory, M.D., Chr. Milbank

Roy E. Jernstrom, M.D. Rapid City

L. J. Pankow, M.D. Sioux Falls

Public Policy & Legislation

D. A. Gregory, M.D., Chr. Milbank

Roy E. Jernstrom, M.D. Rapid City

The Council

Publications

R. G. Mayer, M.D., Chr. Aberdeen

Don H. Manning, M.D. Sioux Falls

Donald Slaughter, M.D. Vermillion

Medical Defense

F. D. Gillis, M.D., (1954) Chr. Mitchell

M. W. Pangburn, M.D. (1952) Miller

C. E. Baker, M.D. (1953) Belle Fourche

Medical School Affairs

Medical Education & Hospitals

C. B. McVay, M.D., Chr. (1954) Yankton

H. Russell Brown, M.D. (1954) Watertown

Donald Slaughter, M.D. (1953) Vermillion

L. J. Pankow, M.D. (1953) Sioux Falls

F. R. Williams, M.D. (1952) Rapid City

Ronald Price, M.D. (1952) Armour

Medical Economics

M. C. Tank, M.D. (1952) Chr. Brookings

P. R. Scallin, M.D. (1953) Redfield

C. R. Stoltz, M.D. (1954) Watertown

Necrology

R. A. Weber, M.D. (1952) Chr. Mitchell

J. A. Lowe, M.D. (1953) Mobridge

R. S. Westaby, M.D. (1954) Martin

Public Health

G. J. Van Heuvelen, M.D., Chr. Pierre

Subcommittees

Cancer

P. V. McCarthy, M.D. (1954) Chr. Aberdeen

Hans Jacoby, M.D. (1952) Huron

D. H. Breit, M.D. (1953) Sioux Falls

Tuberculosis

W. L. Meyer, M.D. (1954) Chr. Sanator

D. S. Baughman, M.D. (1952) Madison

W. T. Judge, M.D. (1953) Milbank

Maternal & Child Welfare

R. E. VanDemark, M.D. (1954) Chr.

Sioux Falls

G. E. Zimmerman, M.D. (1952) Sioux Falls

M. E. Schmidt, M.D. (1953) Watertown

Diabetes

J. W. Donahoe, M.D. (1952) Chr. Sioux Falls

I. L. Schuchardt, M.D. (1953) Aberdeen

B. S. Clark, M.D. (1954) Spearfish

Executive Committee

D. A. Gregory, M.D., Chr. Milbank

R. E. Jernstrom, M.D. Rapid City

R. G. Mayer, M.D. Aberdeen

L. J. Pankow, M.D. Sioux Falls

A. P. Peeke, M.D. Volga

R. E. VanDemark, M.D. Sioux Falls

Mental Health

H. E. Davidson, M.D. (1954) Chr.	Lead
R. J. Quinn, M.D. (1952)	Burke
V. V. Volin, M.D. (1953)	Sioux Falls

Rheumatic Fever & Heart Disease

M. P. Merryman, M.D. (1952) Chr.	Rapid City
John Argabrite, M.D. (1953)	Watertown
D. C. Austin, M.D. (1954)	Brookings

Medical Benevolence

Wm. Donahoe, M.D. (1952) Chr.	Sioux Falls
Wm. Saxton, M.D. (1953)	Huron
J. C. Hagin, M.D. (1954)	Miller

SPECIAL COMMITTEES — 1952-53**Radio Broadcast**

J. C. Rodine, M.D., Chr.	Aberdeen
Paul Reagan, M.D.	Sioux Falls
Donald Fedt, M.D.	Watertown
L. C. Askwig, M.D.	Pierre
R. A. Buchanan, M.D.	Huron
Harvard Lewis, M.D.	Mitchell
C. F. Johnson, M.D.	Yankton
A. A. Lampert, M.D.	Rapid City

Editorial

R. G. Mayer, M.D., Chr.	Aberdeen
Donald Slaughter, M.D.	Vermillion
Wray Tomlinson, M.D.	Mitchell
Don H. Manning, M.D.	Sioux Falls
G. J. Van Heuvelen, M.D.	Pierre
H. R. Wold, M.D.	Madison
H. J. Hare, M.D.	Rapid City
Mary Price, M.D.	Armour
Dagfin Lie, M.D.	Webster

Medical Licensure

Faris Pfister, M.D., Chr.	Webster
J. D. Alway, M.D.	Aberdeen
R. J. Quinn, M.D.	Burke

Veterans Administration & Military Affairs

L. C. Askwig, M.D., Chr.	Pierre
Don H. Manning, M.D.	Sioux Falls
Faris Pfister, M.D.	Webster
J. W. Erickson, M.D.	Rapid City

Spafford Memorial Fund

J. C. Ohlmacher, M.D.	Vermillion
-----------------------	------------

Prepayment & Insurance Plans

C. J. McDonald, M.D., Chr.	Sioux Falls
D. H. Breit, M.D.	Sioux Falls
T. W. Reul, M.D.	Watertown
R. G. Mayer, M.D.	Aberdeen
F. T. Younker, M.D.	Sisseton
A. A. Lampert, M.D.	Rapid City

National Legislation

D. A. Gregory, M.D., Chr.	Milbank
Roy E. Jernstrom, M.D.	Rapid City
R. G. Mayer, M.D.	Aberdeen
H. Russell Brown, M.D.	Watertown

Rural Medical Service

A. P. Peeke, M.D., Chr.	Volga
M. M. Morrissey, M.D.	Pierre
G. J. Bloemendaal, M.D.	Ipswich

Nursing Training

W. H. Saxton, M.D., Chr.	Huron
L. J. Pankow, M.D.	Sioux Falls
E. C. Bobb, M.D.	Mitchell

Workman's Compensation

R. E. VanDemark, M.D., Chr.	Sioux Falls
O. S. Randall, M.D.	Watertown
R. J. Delaney, M.D.	Mitchell

Liason Committee With S. B. H.

W. A. Geib, M.D., Chr.	Rapid City
C. L. Voegel, M.D.	Aberdeen
D. H. Breit, M.D.	Sioux Falls

**Temporary Committee
Grievance Committee**

T. F. Riggs, M.D., Chr.	Pierre
O. J. Mabee, M.D.	Mitchell
J. L. Calene, M.D.	Aberdeen
D. S. Baughman, M.D.	Madison
F. S. Howe, M.D.	Deadwood

REPORTS OF OFFICERS**REPORT OF THE PRESIDENT****To the Officers, The Council and Members
of the South Dakota Medical Association**

Your President begs to report that during the year of his incumbency he has attempted faithfully to perform the duties of his office, in so far as possible, considering the frailties of flesh and the limitations of time and to the best of his ability to interpret those duties.

I have visited each District Society, officially, at least once during the year, in every district where meetings were held and I have been invited. So far as I know there were no meetings of the Rosebud or Mobridge Districts, and no invitation was received to visit them. On nearly every visit I was accompanied by our Executive Secretary, who invariably gave the better speech. A very common reason given for infrequent meetings is the inability to obtain speakers for their meetings because of expense and inaccessability. To correct this situation, I am happy to announce that plans are underway to establish a State Speaker's Bureau to provide, thru our Executive Office, men of ability from our own membership who will, on invitation, and without cost to the Society, present excellent papers and lectures on medical subjects of their choice. Another reason for infrequent meetings is inequitable districting of the State. It is my hope that a re-districting now under consideration may stimulate more activity on the part of the doctors in attending meetings, and more meetings in the districts. Each visitation made was very enjoyable for me. I was able to become better acquainted with the individuals of the several districts, and to hear some of the District's problems and at times, I hope, helped to remedy them. The State Associa-

tion can only be as strong as its component societies, and to that end alone, strong and active District Organizations are necessary.

Without doubt the visitation that made the deepest impression on me was to the Hills District in August, not as one might suppose because of the wonderful meal of trout and all the fixin's Dr. Lyle Hare and his associates served for us, but because of my first experience in presenting "Fifty Year Service Pins" to two wonderful Doctors, who have grown old in the faithful service of their communities. To Drs. Townsend of Belle Fourche and G. H. Miller of Spearfish was given, with the pins, the congratulations and felicitations of the State Association. No honor we could confer could excel that earned by them thru their many years of faithful service to their patients. Later in the Fall it was called to my attention by Dr. Hare that another veteran of years of practice in Sturgis, was rapidly reaching his final call but due to his final illness had dropped out of membership in the Association. He asked if a "Service Pin" might not be presented. I ordered, without authorization of anyone, that a pin be sent to Vice President Roy Jernstrom of Rapid City with a request that he officiate at the presentation. This was done, and before a small group of doctors and the close family, the presentation was made impressively to Dr. F. A. Richards a few days before his death. I have learned that this act contributed much to his happiness during his last few days on earth. To have witnessed the profound emotions of appreciation and pride with which these grand old men receive their pins was a most stirring experience to me.

Numerous AMA Regional Conference Meetings on various activities were attended, notably one on Voluntary Health Insurance held in Sioux Falls, at which progress of non-compulsory insurance plans was discussed and evaluated, and one at Omaha at which Dr. Joe Lawrence and some of his Washington Staff discussed with representatives from Minnesota, Wisconsin, Iowa, Missouri, Kansas, Nebraska, and North and South Dakota, the results of the national elections in our several states. It was obvious that the activity of medical men in informing the voters of the issues at stake had a profound influence on the elections in this area.

I attended the North Central States Conference in Minneapolis, at which I had been honored by being asked to present a paper on "Hospital Service vs. Medical Practice." Despite the great effort and care in the preparation of this paper I fear it was not fully understood or properly appreciated by many of those who heard it. There were some, however, who did appreciate the warnings expressed, and perhaps my paper was a little more than a "voice in the wilderness."

During this past year were inaugurated several new ideas. The newly created Executive Committee was used by me to assist in the selection of new appointments to the various committees, and in several other matters, some being discussed by mail. I believe that utilization of this committee is a most efficient method of selecting the best men possible for service on various committees, and for formulating opinions of policy for the Association between Council and Annual Meetings.

Another inauguration was the appearance of a "President's Message" in each issue of our Journal. Despite some blunders that were made I feel that this is a valuable method of reaching the members periodically by the President, sometimes for encouragement, sometimes for censure, always hopeful of encouragement and inspiration. Quite a few favorable comments have reached me for this page, not a few being from out of our state. I urge the continuance of this page to my successor.

Still another innovation of this year was the Grievance Committee. Before the Committee could be named it became my responsibility to act as a one man committee in several instances. I investigated and satisfied the complaint of a patient in regard to a fee charged for a medical procedure. My explanation was accepted and the fee paid. Another highly critical letter was recognized as the fruit of a psychopathic mind, and the writer was eventually placed where she could be properly treated. A third complaint was investigated by me, but no substantiating evidence could be uncovered, and no action was taken or advised. After the Grievance Committee was formally appointed it deliberated and heard a complaint which it disposed of efficiently albeit, I fear the situation remains unchanged.

A letter of thanks and appreciation was

written to the widow of Dr. O. C. Ericksen late of Sioux Falls, for the creation by her and her family of a student loan fund in Memory of Dr. Ericksen, and in perpetual continuation of the help he had given so many needy medical students during his life. With a similar idea in numerous instances when a floral piece would have been usual for a funeral of former officers of the Association I instructed our Executive Secretary to give a memorial donation to the Medical School Endowment Fund, and individuals were urged to do the same. At the Several Service Club Luncheons at which I was invited to speak in several communities, I usually used as my theme the Endowment Fund of the Medical School and urged contributions and bequests to assist in carrying on the excellent work being done by our Medical School, now fully approved as a preclinical institution. I was also present at the "Ground Breaking Ceremonies" for the new Medical School Building, at which I addressed the assembled dignitaries and didactic brass collars which both AP and Johnny Foster have immortalized as the famous "Short Talk."

I attended several official and unofficial meetings of the Advisory Committee to the Medical School Affairs Committee and the Directors of that Endowment Fund. Constructive action is under way to encourage more and greater gifts to the Endowment Fund. One notable contribution to this fund is the gift of an income property nearly surrounded by the Medical School Campus, by Dr. and Mrs. E. M. Stansbary of Vermillion. It is hoped that this magnificent gesture may instigate an epidemic of similar gifts. As another method of obtaining more funds for Medical education in our State, I gave official approval for the incorporation of a State Chapter of the American Heart Society, thus assuring our State of the major share of any funds contributed to their drives, by South Dakotans. This money is being used for State Heart needs, and this year amounted to some over \$2,000.00. While it is true that this does not reach the Endowment Fund, it does contribute to Medical Education in our State.

Partly by virtue of my office I acted as a member of the Medical Advisory Committee to the State Advisory to Selective Service, as requested by the Draft Office in Washington.

I attended the organizational meeting of the Committee in Pierre, where the committee was favorably received by General Theodore Arndt, the State Draft Director, and his cooperation with this Committee was assured to us. The advices of our Committee have been favorably received and, although some misunderstandings have arisen, I believe that no essential physician has yet been called from any South Dakota Community. Several have become so discouraged over the uncertainty of their status that they have volunteered for active duty. There have been very few instances of a physician having been unwillingly inducted into service from this state.

The Director of the Crippled Children's School and Hospital being built in Sioux Falls for Eastern South Dakota requested that an advisory committee to their organization be named from our membership. Time not allowing for consultation with the Executive Committee in this matter, I asked nine physicians to serve on this committee. I consider it as a high compliment to my judgment and an excellent exhibition of the spirit of public service among our members, that each man asked to serve on this committee accepted with pleasure, and the first meeting of the committee under the chairmanship of Dr. G. E. VanDemark of Sioux Falls, was held on April 6.

In this report I shall not make any mention of any legislative activities. I shall mention only that due to the passage of a certain bill into law, a new board of control was created to oversee Sanator and the State Soldiers Home. This bill was opposed by the Association and bitterly resented by the Hills District. Despite all our efforts the bill did pass and Governor Anderson requested a list of nominees from our Association to serve as Medical Representatives on the Board. Again due to lack of time it was necessary to act without help of the Executive Committee. By this time the appointments will have been made public, and I am not ashamed of my recommendations.

Unofficially I have lent the dignity of the Presidency of our Association to the South Dakota Chapter of the American Academy of General Practice, by having been a charter member of the Chapter, and have attended several meetings held during the year

Privately I have attempted to encourage favorable legislation, both State and National, by expressing my views on matters to our legislators and to the South Dakota members of the Congress and Senate of the United States. Without exception I have received courteous replies and thanks for explaining some unknown or unrealized matter to them, and in more than a single instance the men have voted in accord with the explanation I had furnished them.

There may have been other lesser activities of your president during the year past, some official and some private. Without doubt better qualified men would have done better work. I have tried, at least, not to bring discredit to the Office, the Association or the Profession, and I assure you that it is my belief that any constructive accomplishment during my term has been due to the excellent groundwork laid down by my predecessors, the assistance and cooperation of the officers and the Council, and the support of the Members of the Association.

In closing this report, I wish to offer my service to the future officers in whatever capacity, however humble, in which it may be deemed that I may continue to serve the South Dakota State Medical Association.

L. J. Pankow, M.D.
President

REPORT OF THE PRESIDENT-ELECT

To the Officers and Members of the South Dakota State Medical Association:

I have attended all meetings of the Council and the meetings of the executive committee and have endeavored to fulfill all the duties of the President-Elect.

D. A. Gregory, M.D.
President-Elect

REPORT OF THE VICE-PRESIDENT

The Vice-President wishes to report that he fulfilled all the duties of that office, attending the council meetings, etc. There were no duties to fulfill in the absence of the president and president-elect because those jobs were admirably handled by the persons holding those positions.

Roy E. Jernstrom, M.D.

SECRETARY'S REPORT

On May 29, 1950, your Secretary accompanied by Dr. E. A. Rudolph of Aberdeen, went to Grand Forks, North Dakota, by airplane to attend the Annual Convention of the North Dakota State Medical Association. I appeared before their House of Delegates and, on behalf of the South Dakota State Medical Association, extended an invitation to our neighbors on the north to meet with us in joint session at Aberdeen in 1951. Executive Secretary Foster was also present and joined in the invitation. Although we were cordially welcomed the invitation for 1951 was declined because of previous commitment for their convention to meet at Bismarck. However, the idea of a joint session was favorably received and many of the North Dakota physicians expressed the hope that such a Convention could be held at our 75th Meeting or Diamond Jubilee in 1956.

In July I attended a meeting of the Executive Committee at Watertown, and on October 21st met with President Pankow and Executive Secretary Foster in Sioux Falls to discuss plans for the Annual Meeting in 1951. In November I attended the Annual North Central Medical Conference at Minneapolis. Other South Dakotans in attendance were Doctors Pankow, Brown and Jernstrom and Executive Secretary Foster, Dr. Pankow being one of the speakers on the program.

I also attended the September and January Council Meetings at Huron and discussed the subject "District Society Activities" at the Conference of Councillors and District Society Officers in Huron on January 14th. The usual voluminous correspondence with officers and members of our Association and other Medical Societies, the American Medical Association, and so on, was carried on as in past years.

R. G. MAYER, M.D.
Secretary

TREASURER'S REPORT

Secretary-Treasurer's Account

R. G. Mayer, M.D., Secretary-Treasurer
INCOME

Balance on Hand

May 1, 1950 \$ 506.81

Received from Executive

Secretary Foster 1,200.00

Interest — U. S. Bond 25.00

Total	\$1,731.81
DISBURSEMENTS	
Secretary's Salary	\$600.00
Stenographer	120.00
Bond—Secretary-Treasurer	10.00
A.M.A. Directory	20.00
Social Security Tax	9.00
American Medical Writers	
Assn. dues	5.00
Travel-Grand Forks-Huron	58.50
Telephone and Telegrams ..	12.91
Postage and Envelopes	27.55
Total	\$862.96
Balance on hand	
May 1, 1951	868.85
Total	\$1,731.81

REPORT OF THE EXECUTIVE SECRETARY

For ease in handling, this report is broken down into sections which cover the major duties of the executive-secretary and the office staff.

Public Relations

During the fiscal year, the executive secretary made appearances before 36 groups of businessmen, high school students, ladies clubs, etc., with a total direct audience of 1,547 not counting a possibly much greater audience on two radio program appearances on KELO and KSOO in Sioux Falls. This speaking schedule was somewhat lighter than the year before probably because the heaviest months for public appearances are normally January and February when I was tied up in the legislature this year.

Newspaper stories on these appearances plus our cooperation in the AMA's October advertising campaign gave us probably our best year as far as press relations were concerned. The selection of Dr. R. J. Quinn as General Practitioner of the Year also received much coverage in the press of the State. I would like to commend the representatives of the Associated Press and the United Press for their consistent good coverage of our activities. The same may be said for the Huronite and Daily Plainsman of Huron for their excellent coverage of our Annual Meeting last year.

Placement Service

In helping physicians to find good locations in which to practice, and also assisting communities to get in touch with doctors, we have

continued our placement service in the face of a dwindling supply due to needs of the armed forces. During the year we handled requests from 22 communities, of which 7 have been filled. We also maintained correspondence with 23 physicians, 18 of whom did not see fit to locate in the State up to the time of this report.

Liason With Other Groups

As in the past, much of the executive-secretary's time has been taken in representing the Association at meetings of Allied groups. During the year he attended Medical Association and other organization meetings for a total of 49. These included the AMA annual meeting in San Francisco, the White House Conference on Children and Youth in Washington, D. C., the AMA Interim Session in Cleveland, an AMA regional meeting in Omaha, and the North Central Conference in Minneapolis.

The executive-secretary has been active in the Advisory Committee to Selective Service, the S. D. Mental Health Association, the South Dakota Heart Association, the Governor's Committee on Children and Youth (Interim steering committee) the S. D. Hospital and Home Association, and others.

Publication

The Executive-Secretary, as Business Manager of the South Dakota Journal of Medicine and Pharmacy supervises its operation. As reported in the Committee on Publications annual report, we are now breaking even on the publication, having an income of over \$13,000.00 this year. Our deficit has been paid off with the exception of \$28.00. Although we have had to reduce the number of pages in several issues we feel that the future is bright.

Home Town Medical Care Plan

During the fiscal year we again decreased in the amount of work done for the Veterans Administration. Our gross collections from the V.A. including percentage for operation and reimbursement for losses was \$36,130.31 as against \$42,026.46 last year.

The amount received was inadequate to pay all bills so under the terms of our contract, we have billed the Veterans Administration for those losses.

Legislative

The Association office aided in the work of the Committee on Legislation which is reported elsewhere. The executive-secretary

was an elected member of the State Legislature and was a member of the House's committee on Public Health.

Annual Meeting

The executive-secretary, at the beginning of the fiscal year had the additional duties of moving the annual meeting from Mitchell to Huron after fire destroyed the Widmann Hotel. The meeting was most successful in spite of the move.

Plans for this current annual meeting have taken up much of the time of the office staff.

Military Affairs

This is a new portion of the report, but of necessity, an essential one. The executive-secretary was made secretary of the Advisory Committee to Selective Service which consults with its sub-committees representing the various professional organizations and advises selective service on essentiality.

This group has had before it over fifty cases to advise on — the correspondence and investigation being carried on from the executive office. Through our activities on this committee, we have been able to protect areas with few doctors from reverting to an emergency status as happened occasionally in WW II.

Statement of Operations

May 1, 1950 to April 30, 1951

RECEIPTS

Dues	\$18,125.00
Annual Mtg.	2,585.00
Annual Mtg. Exhibits	617.76
Miscellaneous	416.20
Total Receipts	\$21,743.96

EXPENSES

Salary—Executive	
Secretary	\$7,933.26
Salaries—other	2,369.50
Advertising	30.00
Annual meeting	3,143.48
Bank charges	7.07
Dues and subscriptions ..	906.40
Donation—Benevolent	
Fund	200.00
Essay contest prizes	50.00
Council meeting expense	332.40
Insurance and bond	85.15
Legal services and audit	948.97
Executive expense—	
Dr. Mayer	1,200.00
Postage, freight	
and express	349.99

Painting	130.00
Telephone and telegraph	586.48
Travel	1,965.64
Taxes:	

Personal property ---\$ 39.78

Payroll

153.28

Rent

420.00

Supplies, printing

1,140.91

Miscellaneous

50.42

"Willie"

144.00

Depreciation expense

205.03

Total Expenses\$22,351.98

John C. Foster

Executive Secretary

REPORT OF DELEGATE TO AMA ANNUAL MEETING

June 26-30, 1950

The 99th Annual Meeting of the American Medical Association was held at San Francisco, June 26-30, 1950. More than 10,000 fellows and members attended and the total registration reached almost 24,000.

Dr. Evarts A. Graham of St. Louis, Missouri was granted the Distinguished Service Award for 1950. His accomplishments in the fields of lung surgery and gall-bladder radiography particularly need no elaboration in this report.

John W. Cline of San Francisco is the new president-elect of the AMA. R. B. Robins, Camden, Arkansas, was elected Vice President. Officers re-elected were: J. J. Moore, Chicago, Treasurer; F. F. Borzell, Philadelphia, Speaker of the House; James R. Reuling, Bayside, New York, Vice-Speaker; Geo. F. Lull, Chicago, Secretary; Elected to the Board of Trustees were: Leonard W. Larson of Bismarck, North Dakota, and Thomas P. Murdock of Meriden, Connecticut.

Your delegate attended two other meetings which were held on the Sunday preceding the opening of the AMA Meetings. These were the "Seventh National Conference of County Medical Society Officers" and the "Conference of Presidents and officers of State Medical Associations." Both conferences were concerned with medical economics and attendance was well worth while.

The House of Delegates had its usual busy session and acted on more than 170 pieces of business. The Hess Report was adopted with minor and inconsequential amendments. It

was resolved to oppose President's Reorganization Plan #27. Because federal subsidy always means eventual federal control, it was felt necessary to oppose federal aid to medical education. Dues for 1951 were fixed at \$25.00 and include the subscription to the Journal of the American Medical Association. Fellowship dues are \$2.00 additional and privilege the fellow to select another AMA scientific publication in lieu of the Journal of the AMA.

The Board of Trustees was authorized and directed to initiate and encourage development of a Junior AMA organization for medical students. Other items in the agenda were too numerous to be discussed in this report, but detailed information in their regard appears in the Journal.

The report of the Coordinating Committee for the National Education Campaign was approved. The Board of Trustees expressed satisfaction in the work of Whitaker and Baxter and retained them for another year.

The session of the House of Delegates was notable in that, for the first time, the final session was broadcast over a dual-network, coast-to-coast radio hook-up. The broadcast included the addresses of retiring President Ernest E. Irons; President, Elmer L. Henderson; and President-Elect John W. Cline.

H. Russell Brown, M.D.
Delegate to the AMA

REPORT OF DELEGATE TO AMERICAN MEDICAL ASSOCIATION CLINICAL SESSION

December 5-8, 1950, Cleveland, Ohio

Despite the severe blizzard that blanketed the Great Lakes and Cleveland area during the week preceding the meeting, physician attendance at this clinical session was very satisfactory. Approximately 2,100 physicians attended the program and scientific exhibits, which were of the same quality characteristic of past clinical sessions.

After travel difficulties due to poor flying weather, and using both plane and train, I arrived in Cleveland, Sunday, Morning, December 3rd, to attend special committee meetings. On December 3rd and 4th, several sessions of the Public Relations Conference were attended. This was the third annual conference of this type and the program was excellent and well attended.

The Sessions of the House of Delegates opened on Tuesday morning and 195 of the 198 delegates were present. The fourth recipient of the Association's "Gold Medal" for exceptional services of a general practitioner" is a 74-year-old family doctor practicing at Canton, Massachusetts, Dr. Dean Sherwood Luce. Other nominees for the recognition were: Dr. Jim Camp of Pecos, Texas, Dr. John Strange of Loogootee, Indiana. A large amount of business was handled by the House more smoothly and rapidly than in any previous session. This report will not recount the many items of business taken up, but will refer you to the reports in the Journal of the AMA for detailed information.

Three outstanding things occurred at this meeting and these should be commented upon in this report for emphasis. The most noteworthy of these was the action taken by the Board of Trustees, with the endorsement of the House of Delegates, in allocating one half million dollars of AMA funds to the medical schools without any strings attached. It is hoped that it will be the beginning of a fund of money raised by private donation and philanthropy to assist in the financing of medical education; thereby making unnecessary federal subsidy with its inevitable resulting federal control.

Of importance also was the very favorable report of the coordinating Committee for the National Education Campaign. Great strides have been made in telling medicine's story to the people. As a result the American people in ever increasing numbers are rallying to the support of the medical profession in its fight against socialization of medicine and the drift toward state socialism of our economy in general. During the past year, the number of people covered by voluntary health insurance has increased more rapidly than ever before. While much work remains to be done and conditions will not permit resting on the oars, it is reassuring to know that tangible and rapid progress is being made in our crusade.

The third occurrence of outstanding importance was the presentation of an address to the House of Delegates and a nation-wide radio audience by an outstanding leader in union labor. William H. Hutcheson is general president of the United Brotherhood of Carpenters and Joiners of America, and Vice-

president of the A. F. of L. His address was entitled, "Socialized Medicine is No Bargain." He stated that his union representing 800,000 members had voted opposition to compulsory health insurance. He pledged support to the medical profession in its fight against socialized medicine and state socialism. His address has appeared in the Journal of the AMA and should be read by every doctor.

Permit me to express my appreciation for the privilege and honor of representing the South Dakota State Medical Association as its delegate.

H. Russell Brown, M.D.
Delegate to the AMA

REPORT OF THE COUNCIL

Two meetings of the Council have been held since the Annual Convention at Huron last May. The first meeting was held at Huron on Sunday, September 10, 1950. Six officers and eleven Councilors were present and Attorney Karl Goldsmith and Dr. D. H. Slaughter were also present. Dr. A. A. Lampert, Rapid City, was elected to serve the unexpired term of Dr. R. E. Jernstrom as Councilor for the Black Hills District. Dr. Slaughter made a report of the meeting of the Medical School Affairs Committee and the Medical School Endowment Fund Association, outlining plans for a fund-raising campaign. State legislative matters were discussed and President Pankow appointed the members of the Grievance Committee. A motion suspending dues of members serving actively in the Armed Forces was passed. Minutes of the meeting were published in the October issue of the South Dakota Journal of Medicine and Pharmacy.

The second meeting of the Council was held at Huron on January 14, 1951, in conjunction with the Annual Conference of Councilors at District Society Officers. Six Officers, twelve Councilors and seventeen officers of various District Societies were present. Numerous subjects, district society activities, medical legislation, state health affairs, etc., were discussed. The minutes of the meeting were published in the March 1951 issue of the South Dakota Journal of Medicine and Pharmacy.

G. E. Whitson, M.D.
Chairman of the Council

R. G. Mayer, M.D.
Secretary of the Council

ADDRESS OF THE PRESIDENT L. J. Pankow, M.D.

Fellow Physicians and Ladies, Honored Guests: The presentation of this address, or perhaps I should say the infliction of this address on you, is, for me, an occasion of very definitely mixed emotions. There is the single honor which my Medical Associates have given me by having made me your President; there is a certain pride in having accomplished a few things which I hope time will prove to have been beneficial; and there is a feeling of genuine sorrow that my time of service in an active capacity to this Association, draws close to an end.

I have served this Association in one capacity or another, as District Delegate, Councilor or Officer, since the annual meeting of 1923, and it is with pride that I can state that in those years I have missed but two annual sessions. One absence was in 1935, and was due to my own ill health and absence from the State. The other was in 1938 and was due to a death in my family. In all those years I have tried to serve my District, the State Association, and the Profession to the best of my ability. There have been many times when I have been a thorn in the side of other Members and Officers. I have, I know, made some enemies, and, I believe many friends. Whatever may have been the opinions of my friends and enemies, any changes or reforms that I have espoused or supported, have been, without exception, free of selfish purpose, and completely for the good of the Association and the Profession, as I saw it.

I should be less than honestly human were I to infer, then, that I do not deeply appreciate the privilege you have conferred on me, by making me your President for this past year. I should be less than honest if I did not profess a pride in having had a part in the improvements and reforms which have taken place in the Association during those years that I have been active in it. I should be less than honest if I did not freely admit that none of these improvements came thru me, except as I am, and have been, a part of the whole organization, striving for improvement. Nor would I be human if I did not admit a feeling

of definite sorrow and regret that this now brings to a near close my active participation in these affairs.

What then, shall be the theme of my parting message to you? Is there any point in rehashing the needs of eternal vigilance and active opposition to the attempts of misguided and malignant Federal Agencies to take from us our Freedom of Enterprise in the guise of Public Good? Is there any need of inspiring men and women to greater zeal in combatting disease and death, when they have already dedicated and devoted their lives, their means, and their total energies to that one thing? I see no need for such a talk from me.

My message shall be a plea for unity of purpose and aim, within our own professional ranks, and an unselfish effort by each of us to understand each other, and actively to support the actions and conclusions and purposes of our Association as formulated by our Delegates, Councillors and Officers, any by our individual efforts to help them to form the right and proper opinions and purposes, admitting that we as individual members might be wrong as well as right. Let us, then, be guided by, and loyal to, the majority, and yet refuse to abandon an ideal, if convinced of its merit, and press on eternally, fighting for that ideal, until time shall have convinced the majority of our right, or shall have convinced us of our own wrong.

To you who are of my age or older, I do not have much to say, except to plead for tolerance for the enthusiasm of the younger members. It is they who shall have to carry on the affairs of the Association and of the Profession. I believe that we have built well and solidly, a structure which has made the Practice of Medicine as we now know it, possible in our State. As our Medical Fathers turned over to us a better commonwealth in which to live and practice our Art, so have we striven to further improve things for our Medical Sons and Daughters. As we changed things from our Fathers' time, and often with their apprehension and misgiving, so let us accept the changes and innovations that the younger generation will make on the house that we have built for them.

To the younger members, I submit that what we are handing you to carry on, has been a slow and gradual progression over the years. No great movement or improve-

ment has ever burst into full bloom in any one year. Only by repeated defeat of your new ideas will they eventually involve into an obvious right, and be adopted by a majority. Do not be contemptuous of the old timers' advices or criticisms. Numerically you outnumber them, but in years of medical activity and participation in Association matters, they outnumber you. Judgment in Association policies as well as in diagnosis and treatment, improves with age and experience.

I further suggest to the younger members that one of the best services you can give to your State Association is to keep your District Society active and alert. Arrange for frequent meetings of your District Society for the Scientific Programs and so that Medical Economic and Politic Problems can be discussed. A strong and active District Organization improves the State Association. By keeping interest active in your district problems, you become better able to help solve State level problems and to combat State and National level threats against the freedom of our profession. "The Truth shall make you free" is not an idle promise, but unless we seek that truth, recognize and understand it, it cannot unlock any doors for us; and unless we do face these truths in our local society meetings and understand them there, we shall not recognize them when we meet them in State Association Meetings. This aphorism also applies equally well in our daily relations with our associates, our help and our patients.

Don't be afraid to express yourselves in Medical Meetings. Get your gripes off your chests, and don't go grumbling about them out in the halls. You have no right to complain about what is done if you do not, or have not, fought for your ideals in the meeting. Don't be easily discouraged, for if your idea is right it will come up again and again until, eventually, it will win the support of the majority. Never forget that this is OUR Association, yours, mine, and every other Member's, and each of us has the right to advance ideals and to fight for them.

An active District Society will know what problems and proposals are coming up for consideration at the State Meetings. See to it that you **do** know, thru your Councillor and your Delegates. Then instruct your Delegates on how to act for your District, and

don't expect him to follow your will, if you have never expressed that will to him. Inform your Councillor as to how your District feels about Association matters. His duty is to council the Association for the **benefit** of his District as well as to be a Councillor from the Association to your District.

To all members, young and old, I recommend a solidarity of purpose to improve the Medical World in which we live and earn our living. The action of the majority may not always be right, but until the opinion of the majority can be changed to support other ideas, we must, for the sake of unity and strength against our enemies, stand together for the ideals passed. Then, when finally your different ideas are accepted and passed by the majority, you have the right to expect similar support for that new ideal.

To the New Officers I urgently recommend a spirit of SERVICE to the Association. As officers, we are not rulers of the members, but servants. Our success as officers is not determined by how many orders we give, but on how much good we may have had a part in bringing to the membership and to the profession, and on how well we have been able to get them all to work together. This cannot be accomplished by any **one** alone nor by any small group of us. It must be done by the Membership as a whole, with the Officers as the instruments of the profession, following their will and carry out their wishes. Election to an office is only the offer, the proferment, of an honor; — whether or not we ever merit and attain the Honor, depends on how well we shall have served our Association, while in office.

And now, in turning over the Presidency to my successor, it is with the belief that time alone will tell whether I have had the highest Honor which this Association could confer on me, — or, whether I was **just** your President, during 1950-51.

REPORT OF THE COMMITTEE ON SCIENTIFIC WORK

The scientific program of the 1951 Annual Session of the Association is the work of this committee. This includes:

- "An Improved Technic for the Operative Treatment of Common Anorectal Lesions"—Film
- "Acute Abdomen"—Philip Thorek, M. D.
- "Congenital Abnormalities of the Urinary Tract in Children"—Edith Potter, M.D.
- "Some Interesting Highlights of Orthopedic Practice"—Fremont Chandler, M.D.

- "Intestinal Obstruction"—Philip Thorek, M.D.
- "Tracheotomy and Bulbar Poliomyelitis"—Robert E. Priest, M.D.
- "Backache, Its Diagnosis and Treatment from the Standpoint of the General Practitioner"—Carlo Scuderi, M.D.
- "Bronchogenic Carcinomas Simulating Benign Lesions"—C. Allan Good, M.D.
- "Carcinoma of the Prostate Gland"—Wm. J. Baker, M.D.
- "Aureomycin—Versatile Antibiotic"—Film
- "Renal Tumors"—Wm. J. Baker, M.D.
- "Conduct of Abnormal Labor"—J. H. Randall, M.D.
- "Eruptive Diseases of a Contagious Nature"—Archibald Hoyne, M.D.
- "Medical Care of Cardiac Patients Undergoing Surgery"—R. D. Pruitt, M.D.
- "Liver Biopsy"—M. H. Stauffer, M.D.
- "Malignancy of the Female Genital Tract"—J. H. Randall, M.D.
- "Anxiety in Pediatrics"—Reynold A. Jensen, M.D.
- "Malignancy of the Skin"—C. W. Laymon, M.D.
- "The Academy of General Practice"—Mac F. Cahal
- "The Rationale and Technique of Endocrine Replacement in the Aged Female, and a Preliminary Result Report"—W. H. Masters, M.D.
- "Head Injuries"—Roland M. Klemme, M.D.
- "X-Ray Analysis of the Pelvic in Pregnancy"—B. S. Kalayjian, M.D.
- "How Much Should a Physician Earn"—Frank G. Dickinson, PhD.

L. J. Pankow, M.D.
D. A. Gregory, M.D.
R. G. Mayer, M.D.

REPORT OF COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Being a legislative year, the Committee, through its sub-committee, was quite active. The Medical Association sponsored five bills, four of which became law. These four were:

Animals in city pounds may be used for research.
Coroner may order autopsy.

Increase in employers liability for Workmen's Compensation.

\$203,000.00 appropriation to equip the new Medical Science Building at the University of South Dakota.

The fifth bill concerned the use of the name "Doctor" by those practicing the healing arts. This was defeated in the House of Representatives.

The Association was interested in another 12 bills which concerned public health and expressed itself on the bills at committee hearings.

Nationally, the committee expressed opposition to three bills none of which have yet been passed. These were (1) Federal Aid to Medical Education, (2) Free Medical Care for Armed Service Rejectees, (3) Compulsory Health Insurance.

The committee urges that a vigilant watch be kept on all Federal Legislation that might produce "socialized medicine" under the guise of national defense.

L. J. Pankow, M.D.
D. A. Gregory, M.D.

REPORT OF THE COMMITTEE ON PUBLICATIONS

The South Dakota Journal of Medicine and Pharmacy, during the fiscal year, has carried 378½ pages of medical, pharmaceutical, and editorial material. This is a decrease of 63½ from that of last year and a decrease of 86½ from the year before.

The Journal carried 317½ pages of advertising matter which is an increase of 32½ pages over last year and an increase of 46½ pages over the pre-

vious year.

On the financial side, the Journal took in \$33,107.99, which is its best year for income, and had expenditures of \$12,401.89. These disbursements include almost complete retirement of indebtedness, which last year stood at \$1200.00. At present there is a balance of \$706.00 in the bank, and outstanding bills of \$734.00, leaving a total deficit of only \$28.00. Actually, the Journal has had a profitable operation for the past two years and if advertising income maintains its current trend it should continue to do so.

The Committee wishes to commend Mrs. Dorothy Weck, assistant editor, for her splendid effort in preparing the Journal for publication.

During the year the Association, through its Rural Health Committee, published a health survey, which is being distributed at the time to the Annual Meeting.

The Committee recommends that the Journal be provided to honorary members of the two sponsoring associations at no cost in appreciation of their years of service in their professions.

R. G. Mayer, M.D.
D. H. Manning, M.D.
Donald Slaughter, M.D.

REPORT OF THE COMMITTEE ON MEDICAL DEFENSE

During the past year of 1950-1951, no matter pertaining to medical defense has been brought to the attention of the committee, hence a negative report.

F. D. Gillis, M.D.
M. W. Pangburn, M.D.
E. H. Brock, M.D.

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Your Committee on Medical Education and Hospitals begs to report;

First on Federal Aid to Medical Education—The Problem of Federal Aid to Medical Education is being actively considered by Congress. Your committee on Medical Education and Hospitals feels that each physician must decide whether he wishes further Federal Aid and regimentation or whether he still considers medical practice as a part of our system of private enterprise. If we favor Federal Aid to Medical Education we are possibly subscribing to eventual (a) dictation of medical school policies, (b) appointment of medical school facilities by the Federal government, (c) selection of medical students on a political basis, (d) assignment of physicians to specified localities, (e) compulsion of type of practice or specialty to be pursued.

This committee urges that physicians of the South Dakota Medical Association further combat Socialistic trends by taking definite action in expressing their support of medicine as a part of private enterprise by (a) contributing to the American Medical Education Foundation or (b) contributing to the South Dakota Endowment Fund or (c) contributing to the medical school of his choice. Each physician in South Dakota should give at least \$100.00 annually to one of these methods of building a living endowment for our medical schools. If Senate Bill 337 has not been defeated at the time of the annual session of the South Dakota State Medical Association the members should be requested to write their legislators in Washington.

Due to the urgency of this matter and the present status of Senate Bill 337 your committee requested the Executive Secretary of this Association to outline this committee's views in a letter to all members.

Second, on Hospital staff membership for physicians not members of the South Dakota State

Medical Association—We feel that all doctors of medicine practicing in South Dakota should be members of the District and State Medical Association. We further believe that membership in the District Medical Society should be a prerequisite for hospital staff membership. We suggest that the House of Delegates of the S.D.S.M.A. authorize this committee to obtain applicable portions of the by-laws from the various hospitals in the state, and that this committee review the by-laws and make recommendations at a later date.

Third, on Staff membership for rural physicians—In a vast, mechanized, predominately rural state such as South Dakota we feel that every encouragement should be given to physicians showing an interest to locate in rural areas. The Federal Government has repeatedly emphasized the maldistribution of physicians and has used this as an argument for socialized medicine.

This committee feels that qualified rural physicians located at reasonable distances from urban hospitals should be accepted for staff membership. It is believed that such staff memberships should include a years probationary period, attendance at staff meetings, and sponsorship by an urban physician on the regular hospital staff. We request that the House of Delegates authorize the Executive secretary to secure the by-laws of the various hospitals in South Dakota relative to staff membership and that this committee make a report at a later date.

W. H. Saxton, M.D.
R. A. Buchanan, M.D.
Wayne Geib, M.D.

REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS

No matter has been referred to the committee and no action has been taken by the committee, hence a negative report.

C. R. Stoltz, M.D.
M. C. Tank, M.D.
P. R. Scallin, M.D.

REPORT OF THE COMMITTEE ON NECROLOGY

The Committee on Necrology wishes to report the death of the following members of this Association and those physicians who were not members of the Association during the past year.

L. E. Jordan, M.D., Chester, South Dakota, passed away on June 22, 1950. Death was due to a coronary.

C. L. Wendt, M.D., Canton, South Dakota, passed away on September 12, 1950. Death was caused by a stroke.

P. P. Ewald, M.D., Lead, South Dakota, died on August 17, 1950. Death was due to a coronary.

T. D. Jones, M.D., Aberdeen, South Dakota, passed away on September 16, 1950.

R. J. Wieseler, M.D., Sioux Falls, S.D., died on October 11, 1950. Death due to a carcinoma.

E. E. Torwick, M.D., Volga, South Dakota, passed away October 1, 1950.

F. A. Richards, M.D., Sturgis, South Dakota, died November 27, 1950.

F. M. Newman, M.D., Presho, South Dakota, passed away in 1950.

M. D. Jorgenson, M.D., Watertown, South Dakota, died April, 1951.

J. B. Egan, M.D., Dell Rapids, died May, 1951.

V. I. Lacey, M.D., Yankton.

B. B. Leonard, M.D., Yankton.

G. E. Whitson, M.D.
R. A. Weber, M.D.
J. A. Lowe, M.D.

**PUBLIC HEALTH COMMITTEE,
SUBCOMMITTEE ON CANCER**

During the past year we have been very active in our financial aid to the medical school at Vermillion, having given a total of \$7,000; \$3,000 for the purchase of a Scopicon microscopic and \$4,000 for the purpose of research. We have supported the Tumor Clinic at Yankton and Sioux Falls, total of \$300.00 each, we have again granted a course in cancer nursing to a registered nurse, at Memorial Hospital, New York, a total of \$500.00. This years fellowship was taken by Miss Marion B. Hayberg, Methodist State Hospital, Mitchell, South Dakota.

We are continuing a biopsy service for the indigent, when such tissue is sent to a registered pathologist located in South Dakota.

We are at the present time arranging for the procurement and distribution for use by indigent patients androgen medication for those cancer patients needing this type of treatment.

We have also given financial aid to six patients living in five different counties in the state.

D. H. Breit, M.D.
Hans Jacoby, M.D.
P. V. McCarthy, M.D.
R. L. Ferguson, M.D.

**PUBLIC HEALTH COMMITTEE,
SUBCOMMITTEE ON TUBERCULOSIS**

The death rate from tuberculosis shows a definite decline during the last several years. In 1947, the rate per 1000 population was 3.1, 1948—2.0, 1949—1.8, 1950—1.7 (preliminary figure). This decrease has not been as rapid as we would like to have it. It is the impression of this committee that the slow drop in the death rate is largely due to the high rate among the Indian population. Perhaps this can only be controlled by more intensive education among the Indians and more strict isolation.

We would like to suggest, when possible, the Department of Health employ a full time physician to do contact work with tubercular individuals. This physician should have power to compel isolation either in the home or in the Sanatorium. He should have power to investigate suspected cases of tuberculosis who are contacts of active cases. We appreciate the fact that this will require additional expenditures, but we feel that early detection and isolation of active cases is absolutely essential if the death rate is to show a marked decrease.

We regret the recent action of the Legislature removing the Sanatorium from the State Department of Health and placing it under a board with another institution with which it has no functional similarity or connection. We feel that the sanatorium is strictly a Public Health institution and as such it properly belongs under a Public Health Department. We feel that at least a majority of the Supervisory Board should be of Physicians.

We move the adoption of the above report.

We also recommend that a copy of this report be forwarded to:

- (1) Public Health Committee.
- (2) State Affairs of both the House and the Senate of the South Dakota State Legislature of the session just passed and a copy prepared for the above committees of the next regular session.

W. L. Meyer, M.D.
D. S. Baughman, M.D.
W. T. Judge, M.D.

**PUBLIC HEALTH COMMITTEE,
SUBCOMMITTEE ON MATERNAL
AND CHILD WELFARE**

The chairman of this committee served on the Governor's Committee for the White House Confer-

ence on Children and Youth. Meetings were attended and a A.C. H. report was submitted to be used by them.

G. E. Zimmerman, M.D.

REPORT OF THE DIABETES COMMITTEE
No report.

**REPORT OF THE COMMITTEE ON
MENTAL HEALTH**

This committee has not been called upon during the past year for any matters pertaining to mental health, hence a negative report.

F. D. Gillis, M.D.
R. J. Quinn, M.D.
J. W. Argabrite, M.D.

**REPORT OF THE COMMITTEE ON
RHEUMATIC FEVER AND HEART DISEASE**
No report.

**REPORT OF THE COMMITTEE ON
MEDICAL BENEVOLENCE**

There has been no meeting of this committee. The funds consist of two items. (1) Moneys in the Savings account of the Madison Branch of the Northwest Security National Bank of Sioux Falls in the amount of \$1491.50 and (2) 13 Series F Bonds with cash value of \$2132.37 and maturity value of \$2550.00. These bonds are deposited in the Secretary's personal deposit box in the aforementioned bank. A detailed account of the additions to the fund during the past year follows. There have been no expenditures.

Balance on hand May 1, 1950	\$3087.34
May 3, 1950 State Auxiliary	287.00
June 30, 1950 Interest	7.41
December 29, 1950 Interest	8.91
April 19, 1950 S. D. State Medical Ass'n 1950	200.00
April 20, 1951 Appreciation of Bonds	33.21
Total	\$3623.87
Savings Account N.W. Security Nat'l Bank of S.F. Madison	\$1491.50
Cash Value of Bonds April 20, 1951	2132.37

Number	Maturity Value	Maturity Date	Cash Value April 1951
D 562822F	500.00	April '59	383.50
C 1593091F	100.00	April '59	76.70
C 1593090F	100.00	April '59	76.70
D 562822F	500.00	April '59	383.50
M 525066F	1000.00	April '55	861.00
D 267134F	500.00	April '55	430.50
C 588509F	100.00	April '55	86.10
Q 288335F	25.00	April '55	21.52
Q 288334F	25.00	April '55	21.52
Q 288333F	25.00	April '55	21.52
Q 139359F	25.00	Oct. '54	22.17
Q 139328F	25.00	Oct. '54	22.17
Q 683498F	25.00	June '56	20.87
C 825506F	100.00	Oct. '55	86.10
	2550.00		2132.37

C. E. Sherwood, M.D.
Wm. Donahoe, M.D.
J. C. Hagin, M.D.

REPORT OF THE GRIEVANCE COMMITTEE

The Grievance Committee met at Redfield January 7th. Present were Drs. Riggs, Baughman, Mabee, Calene, Pankow, and executive secretary Foster.

The committee considered the establishment of a modus operandi as prescribed by the House of Delegates at the last meeting.

The following procedures were established (1) the grievance will be placed in writing before the

secretary of the committee who is executive secretary of the Association or any member. The Grievance will then be referred to the chairman of the committee to investigate the matter who is not located in the same medical district in which the grievance originated. If the Grievance can not be properly settled upon investigation of the individual member it shall then be referred to the full committee for deposition. If the committee is unable to satisfactorily settle the Grievance, final disposal would be made by the Council of the Medical Association.

Upon completion of establishment of the above procedures, the committee heard a grievance and discussed it with the parties concerned. Suggestions for an amicable settlement were made by the Committee.

The committee has had more grievances referred to them since that time, which have as yet not been resolved.

T. F. Riggs, M.D.
O. J. Mabee, M.D.
J. L. Calene, M.D.
D. S. Baughman, M. D.
F. S. Howe, M.D.

REPORT OF THE EXECUTIVE COMMITTEE

The Executive Committee met three times during the year. The first time in Watertown in July; those present were Drs. Jernstrom, Pankow, Gregory, Whitson, Mayer, Brown, and executive secretary Foster. The committee discussed committee appointments with the new president.

The second meeting was also held in Watertown, on May 6th; those present were Drs. Gregory, Pankow, Mayer, Brown, Whitson, and executive secretary Foster. The president-elect called the meeting to discuss committee appointments for the coming year.

The third meeting was held June 2nd, 1951, in Aberdeen to consider recommendations to be made to the Council. Present were Drs. Gregory, Pankow, Mayer, Jernstrom, Whitson, and executive secretary Foster.

L. J. Pankow, M.D.
D. A. Gregory, M.D.
Roy E. Jernstrom, M.D.
H. R. Brown, M.D.
G. E. Whitson, M. D.
R. G. Mayer, M.D.

REPORTS OF SPECIAL COMMITTEES REPORT OF THE COMMITTEE ON RADIO BROADCASTS

The activities of the broadcast committee have not been functioning as a unit this past year. The various districts or societies have taken it upon themselves to function independently in this field, these being; Yankton, Sioux Falls, Aberdeen, Watertown. There has been a great deal of difference and effort in the various sections as you will see in the report.

More specifically, the activities of the various areas are as follows:

- (1) **Rapid City**—Six (6), five minute recordings were made during the year by local doctors but were not used.
- (2) **Watertown**—Has sponsored four (4) ten minute recordings, supplied by the American Cancer Society.
- (3) **Sioux Falls**—Have for the past six or seven years been sponsoring programs supplied by the AMA. These have been mostly dramatized medical histories and usually consist of one 15 minute program a week for 52 weeks of the year. The cost of these programs have been born by station KSOO, as a public service feature.
- (4) **Aberdeen**—Has aired sixteen (16) one minute spot announcements with regard to Socialized

Medicine. These have been sponsored by the AMA and cost about \$112.00. In addition there were twelve one minute and eight half minute spot announcements that were sponsored by the local drug and insurance companies. The latter cost about \$60.00.

- (5) **Yankton**—The Yankton District, under the name of the Sioux-land Medical Society have done the greatest amount of work in Radio Broadcasting in the state. Their programs have consisted of one fifteen minute period weekly for twenty weeks during the year. The contents of these programs were Socialism in general, with spot announcements during the period, against socialized medicine. The cost has been born by the Society and was raised by subscription from the surrounding area. These programs cost about \$1700.00 during the year.

It is the opinion of the committee this endeavor has great possibilities. However, to be most effective, it should be coordinated on a state-wide basis.

J. C. Rodine, M.D.
Paul Reagan, M.D.
Donald Fedt, M.D.
L. C. Askwig, M.D.
R. A. Buchanan, M.D.
Howard Lewis, M.D.
V. I. Lacey, M.D.
A. A. Lampert, M.D.

REPORT OF THE EDITORIAL COMMITTEE

The Editorial Committee reiterates its plea for more Scientific Articles and Clinical Case Reports from South Dakota physicians for publication in the South Dakota Journal of Medicine and Pharmacy. The majority of our scientific articles come from out-of-state sources. Papers by clinicians in our own state would be of great interest for obvious reasons, and, after all, that was one of the chief reasons for establishing our own Journal.

News items about our own members are always welcome, and editorials and comments will be gratefully received. The President's Page, inaugurated this past year by Dr. L. J. Pankow, presented subjects of timely interest which the Editorial Committee hopes will be continued by future Presidents.

R. G. Mayer, M.D.
Donald Slaughter, M.D.
Wray Tomlinson, M.D.
C. B. McVay, M.D.
G. J. Van Heuvelen, M.D.
W. H. Karlins, M.D.
A. P. Peeke, M.D.
G. R. Bartron, M.D.
Paul Tschetter, M.D.
H. J. O'Hare, M.D.
D. H. Manning, M.D.
J. W. O'Brien, M.D.
G. C. Torkildson, M.D.

REPORT OF THE COMMITTEE ON MEDICAL LICENSURE

Your committee on Medical Licensure reports that since the last report there were twenty-one doctors licensed by examination and twenty-five by reciprocity.

Lyle Hare, M.D.
J. D. Alway, M.D.
F. F. Pfister, M.D.

REPORT OF THE COMMITTEE ON VETERAN'S ADMINISTRATION AND MILITARY AFFAIRS

The committee met on April 22, 1951, at Huron, South Dakota, Drs. Gelber, Pfister, Manning and Askwig attending.

Under the head of Military Affairs, the Committee concluded that no appropriate action or

suggestions could be made until concrete policies now being formulated in Washington are published.

The Civil Defense program for the State of South Dakota is proceeding very satisfactorily; all enabling legislation necessary has been passed; and the Governor's committee is functioning well.

We urge all members of the State Medical Association to cooperate fully with the regional deputies in formulating medical and hospital care plans in case of disaster.

L. C. Askwig, M.D.
F. F. Pfister, M.D.
M. R. Gelber, M.D.
T. J. Billion, M.D.

SPAFFORD MEMORIAL FUND

No report.

REPORT OF THE COMMITTEE ON PREPAYMENT AND INSURANCE PLANS

During the past year the committee has approved the hospital and surgical plans of the Paul Revere Insurance Company. This policy is non-cancellable once the premium is paid and carries with it an optional rider for catastrophic family illness.

While this policy does not include all the features of the original South Dakota Pre-Payment Plan, its noncancellability makes it an excellent policy for family use. The committee hopes soon to approve other plans which have been submitted to us.

C. J. McDonald, M.D.
T. W. Reul, M.D.
Roy E. Jernstrom, M.D.
R. G. Mayer, M.D.
B. R. Skogmo, M.D.
F. T. Younker, M.D.

NATIONAL LEGISLATION

No report.

REPORT OF THE COMMITTEE ON RURAL MEDICAL SERVICE

The chairman of this committee attended the second National Conference on Rural Health held at Memphis, Tennessee on February 23, 1951. It was evident that there was a growing sentiment that the local areas would and could solve their own problems with the facilities that they have at hand. It was inspiring to see how much was done by local people with so little. Not only had they improved the health conditions, but they improved the morale of the people by building up confidence in themselves and feeling that they could solve their own problems.

This year we again made a survey of the state, trying to find out what has been accomplished in five years in regard to the number of doctors per population, nurses per population, number of hospital beds per population and other pertinent facts, which will be printed at a future date.

A. P. Peeke, M.D.
M. M. Morrissey, M.D.
G. J. Bloemendahl, M.D.

REPORT OF THE COMMITTEE ON MEDICAL SCHOOL AFFAIRS

The committee has been busy again this year. For the most part it has concerned itself with obtaining adequate appropriations for the Medical School. As chairman of the committee it is a pleasure to sincerely acknowledge the tremendous cooperation and real assistance which has been given each of the members of the Committee by our Congressman-Executive Secretary, John Foster, to Mr. Karl Goldsmith, and to the many physicians who responded wholeheartedly to the Committee's recommendation that key personages should be contacted relative to an adequate budget. Ap-

pended hereto are the minutes of the two committee meetings:

COMMITTEE ON MEDICAL SCHOOL AFFAIRS
3:00 p.m. January 13, 1951

Those present: Donald Slaughter, M.D., L. J. Pankow, M.D., F. F. Pfister, M.D., W. H. Saxton, M.D., F. R. Williams, M.D., C. B. McVay, M.D.

Discussion of budget requirements for operation of medical school for the bienium.

Committee recommended to Council that the Council set recommendation that appropriation be increased for medical school.

Committee further recommends to Council that a placement of plaque be made in new medical building in honor of J. C. Ohlmacher, M.D.

Adjourned on motion at 4:30 p.m.

COMMITTEE ON MEDICAL SCHOOL AFFAIRS
12:20 a.m. September 10, 1950

Those present: Doctors Brown, Pankow, Pfister, Saxton, Slaughter, and Executive Secretary, John Foster.

The Chairman described the budget of the Medical School for the next bienium as well as an amount of money to the extent of fifty thousand dollars as a minimum for equipping the new medical laboratories building.

It was the consensus of the Committee that all second year students serving clinical clerkships should write and thank the Doctor under whom they served "if they felt grateful" for their month of service.

The committee felt that a system of rotation for clinical clerkships should be set up so that from year to year there would be changes in the make-up of the preceptors. This seemed to be a practical necessity because there were many more students requests for students on such a basis than there were students.

It was agreed that the Secretary would send to the special legislative committee composed of Doctors Pankow, Gregory, Morissey, and Karl Goldsmith, attorney for the State Medical Association, the budget requests for the next bienium.

The meeting adjourned at 11:50 a.m.

Since the Council in effect gave permission and authority to the Committee on Medical School Affairs to serve as the Board of Directors for the South Dakota Medical School Endowment Association, it is well to relate certain of the activities which have taken place within the Board during the past fiscal year. Appended hereto you will find the minutes of two regular and one special meetings of the Board of Directors:

MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH DAKOTA MEDICAL SCHOOL ENDOWMENT ASSOCIATION

The meeting was called to order on 9 September 1950 at 4:00 p.m. in the Marvin Hughitt Hotel in Huron, South Dakota, by president W. H. Saxton.

The President asked that the Secretary introduce those present. The minutes of the previous meeting were read and approved.

A letter from Governor Mickelson expressing his continued interest in the Association and regret that at the last minute he couldn't be present was read by the Secretary.

President Saxton then made a few appropriate remarks as to the purpose of the endowment association.

A discussion concerning changing one word in the Articles of Incorporation led to a motion by Dr. Pfister, seconded by Dr. Howe, that the Articles of Incorporation stand as drafted. Motion carried.

A bill was presented by the Secretary for \$38.52 for Association stationery submitted by the Midwest-Beach Company of Sioux Falls, South Dakota. A motion by Doctor Pankow, seconded by Dr. Pittinger was made that this bill be allowed.

Motion carried.

A very fine and spirited discussion took place next with respect to just how it would be best to implement a program and/or a campaign to bring in money for the Association. After a thorough review of many suggestions, it was moved by Dr. Pankow and seconded by Dr. Pittinger that the Secretary of the Association be authorized with such help as he sees fit to call upon, to draw up letters and/or other circulars to be directed to (1) medical alumni, (2) life insurance companies in South Dakota, (3) the Pharmaceutical houses in South Dakota and in the United States, (4) Easter Seal Campaign group, (5) Bar Association, (6) Doctors of Divinity, (7) Funeral Directors, (8) Physicians in the State, (9) Widows of physicians, (10) Bankers of South Dakota, and others and upon completion of a suitable letter for each of those groups that same be compiled in a semi-final form and a copy of each be sent to the Board of Directors and Associate Directors for approval, and when approval by said Board has been given that expenses then be allowable to circularize them. This motion was carried.

It was moved by Dr. Pittinger and seconded by Dr. Pankow that the Dean of the Medical School be instructed to make arrangements for a memorial lecture to be given at the University of South Dakota in Vermillion at the discretion of the Dean during the academic year and that \$50.00 or more for expenses of same be guaranteed by Mr. Joe Messer of Watertown. This motion was duly carried. It might be said that the reason behind this motion was to tie in the medical students with the endowment association and in the discussion which preceded this motion, Mr. Messer made a very fine suggestion that all medical students should be organized so that, let us say, after the 29th or 25th year following their graduation, they would be able to endow the Association with a total sum of five or ten thousand dollars or more.

It was suggested that the name of Dr. J. C. Ohlmacher be tentatively chosen for the first endowment association lecture to be given at Vermillion as noted above.

It was moved by Dr. Pankow and seconded by Dr. Howe that a copy of the minutes of this meeting be mailed to each member of the Board; Directors as well as Associate Directors. This motion was also carried.

Mr. Karl Goldsmith, who was present at the meeting, advised us that he will see Mr. George Kienholz at Pierre relative to a scholarship for the Association from the Easter Seal Campaign Fund.

The meeting adjourned at 4:35 p.m.

Those present at the meeting were Doctors W. H. Saxton, H. R. Brown, L. J. Pankow, Faris Pfister, F. R. Williams, Donald Slaughter, who are members of the Board of Directors. Associate Directors present were Mr. Robert Lamont, Guy Bjorge, Mr. Joe Messer, Doctors E. S. Howe, E. A. Pittinger. In addition, John Foster, Executive Secretary of the State Medical Association, and Mr. Karl Goldsmith, consulting attorney for the State Medical Association were present.

Respectfully submitted,
Donald Slaughter, Secretary

MINUTES OF THE BOARD OF DIRECTORS

The Board of Directors met in the Marvin Hughitt Hotel in Huron, South Dakota, on Saturday, 13 January, 1951. Those present were Drs. Saxton, Williams, Pfister, McVay, Brown, Pankow, Slaughter and Assistant Secretary Foster.

The meeting was called to order at 4:00 p.m. by Chairman Saxton. The minutes of the special meeting held in Sioux Falls on 16 October, 1950 were read and approved.

Pfister moved and Pankow seconded that the

Board of Directors accept Dr. Stansbury's generous bequest. Motion carried.

Pankow moved and Pfister seconded a motion that a suitable letter be addressed to Dr. E. M. Stansbury and his wife thanking them for their bequest and suitable publicity be given for same. Motion was carried, unanimously.

Meeting adjourned at 5:15 p.m.

Respectfully submitted,
Donald Slaughter, Secretary

MINUTES OF SPECIAL MEETING OF THE SOUTH DAKOTA MEDICAL SCHOOL ENDOWMENT ASSOCIATION

A special meeting was held in Sioux Falls in the Carpenter Hotel at 9:00 p.m. in October, 1950.

Present were L. J. Pankow, director; George Stevens and Pierce McDowell, associate directors; Donald Slaughter, secretary; John C. Foster, assistant secretary; Robert E. VanDemark, Councilor for Sioux Falls District.

After a considerable discussion it was agreed that a letter should be sent to all doctors in the state outlining the aims of the Endowment Association and urging that all physicians cooperate with the venture. This letter would go out over the signature of the President of the State Medical Council, Dr. G. E. Whitson. It was also suggested that after the above letter was sent out that the Secretary would write to Drs. Hare, Howe, White-side (Aberdeen) and Westaby (Madison) and ask for the names of the South Dakota Alumni who have distinguished themselves and in turn ask the above mentioned four doctors to write these alumni about the Endowment Association. It was later suggested that the same letter be written to Dr. Silas Hohf in Yankton, Dr. Riggs in Pierre, and Dr. E. H. Richter in Hunter, South Dakota.

It was suggested that the Secretary write the newer alumni—those finishing the last fifteen or twenty years.

Dr. George Stevens of Sioux Falls was requested to write the widows of M.D.'s who would be in a position to contribute to the Endowment Association.

Mr. Pierce McDowell of Sioux Falls accepted the responsibility of writing to the Homestake Gold Mine, the utilities companies, the packing houses and in contacting trust officers of banks. In this connection, he made the excellent suggestion that local M.D.'s should contact their local bankers as well as their local druggists.

It was suggested that Mr. Joe Messer of Watertown write the ministers and funeral directors in South Dakota suggesting memorials for the Endowment Association in place of flowers.

It was finally suggested that Mr. Fred Warren of South Dakota—Sioux Falls—should contact certain groups of attorneys in the state for the Endowment Association.

Since the last regular meeting in September the following checks have been received payable to the Endowment Association:

1. Dr. Bunker—\$22.00
2. Dr. Donahoe—\$50.00

Respectfully submitted,
Donald Slaughter, M.D.

Since the special meeting held on 16 October, 1950, your Board of Directors has had the privilege of accepting a most generous bequest given through the auspices of Dr. and Mrs. E. M. Stansbury of Vermillion. This gift in real property amounts to an excess of \$25,000. In addition, a check for \$50.00 from Dr. Lyle Hare of Spearfish and one from Mr. and Mrs. Joseph Messer of Watertown for \$100.00 have been received. The total worth of the Endowment Association in cash at the present time is \$1,130.90 and in real property the Endow-

ment Association is worth an excess of \$25,000.00.

It is obvious that while a few contributions have been made, not enough attention has been paid by the majority of the physicians in South Dakota to this extremely worthwhile cause. Certainly, I feel sure, that those who practice in this state would prefer to send their checks for purposes outlined in the Constitution and By-Laws of the Endowment Association and it is to be hoped that a project under way will point up various aspects and possibilities of such Endowment Association so that we may anticipate a better response in the future.

Committee on Medical School Affairs

H. Russel Brown, M.D.
C. B. MvVay, M.D.
L. J. Pankow, M.D.
W. H. Saxton, M.D.
F. R. Williams, M.D.
Donald Slaughter, M.D.

Board of Directors of South Dakota Medical School Endowment Association

H. Russell Brown, M.D.
C. B. MvVay, M.D.
L. J. Pankow, M.D.
F. F. Pfister, M.D.
Donald Slaughter, M.D.
F. R. Williams, M.D.
W. H. Saxton, M.D.

REPORT OF THE COMMITTEE ON NURSING TRAINING

The Nurses Training Committee was not particularly active except in an advisory capacity to the State Nurses Committee.

One of their big projects was a survey of the nursing needs and resources in the state. A brief summary of their main findings are:

1. There are seven accredited schools of nursing, four of whom have an association with a college having a basic collegiate degree program.
2. There are approximately 700 nurses in training — more than any other comparable state except North Dakota, and above the national average.
3. School policies to protect student health shows a well planned program.
4. Scholarships and loans are accessible in all schools.

The nursing organization would like to develop facilities within the state for specialized training, such as psychiatric nursing at Yankton State Hospital. Also, they would like to develop rural hospital community experience for the smaller rural hospitals.

Other problems to be studied are:

1. Nurse loss to other states and how it can be reduced.
2. Student nurse withdrawal and how it can be decreased.
3. How to provide complete study within the state.

It is the general observation of the medical profession that the general bedside nursing care is now given by the older graduates, married or widowed, who took their nursing many years ago. We fully appreciate them but wonder where the younger nurse is — probably in administrative work as the collegiate degree program now fits them for.

Who will do bedside nursing in ten to twenty years is a serious problem that must be answered by the nursing profession — will it be practical nurses or R.N.'s with good sound bedside training that will not require five years of work.

W. H. Saxton, M.D.
L. J. Pankow, M.D.
E. C. Bobb, M.D.

REPORT OF THE COMMITTEE ON WORKMEN'S COMPENSATION

At a recent session of the South Dakota State

Legislature, the benefits under the Workmen's Compensation law were increased to \$300.00 for the medical doctor and \$700.00 for the hospitalization. Under the hospital bill are included the body aids and artificial limbs. While this increase in no way corresponds with that of our neighboring states, and is much less than originally recommended by the committee, it is a definite improvement over the previous limitation. This bill was introduced by the labor group and indicates the value of working with other groups on legislative problems which are a common concern to all. There have been no other problems brought before the committee and there have accordingly been no meetings.

Robert E. Van Demark, M.D.
O. S. Randall, M.D.
R. J. Delaney, M.D.

LIAISON COMMITTEE WITH STATE DEPARTMENT OF HEALTH, DIV. LABS.

1. Serological test for syphilis evaluation studies.

The State Department of Health conducts yearly evaluation studies of all laboratories performing serological tests for syphilis. The State Department of Health has arbitrarily ruled that only one laboratory or individual in a city be permitted to perform premarital serological tests for syphilis. This creates a monopoly for the Health Department in Rapid City and Sioux Falls, discriminating against private, clinic and hospital laboratories.

Your committee suggests that evaluation studies be done on a monthly basis and that the House of Delegates request the Department of Health to automatically approve the performance of premarital serological tests for syphilis by any laboratory rating satisfactorily in the evaluation studies if the laboratory is supervised by a pathologist. If the laboratory is supervised by a physician considered qualified by the State Health Commissioner the physician may request approval.

2. Free Rh typing.

The State Department of Health at present does free Rh typing on all prenatal serological tests for syphilis. Your committee feels that the problem is not whether the State Department of Health should perform free Rh typings. We feel the question is whether Rh typing is a public health function to be paid for by public funds in competition with private practitioners of medicine. Your Committee feels that settlement of this question should be deferred for further study.

Contraception and fertility.

Correspondence from the Washington Institute of Medicine Research Foundation was referred to this committee. This foundation is undertaking a national wide study relative to the medical and legal aspects of contraception and fertility. Your committee feels that a survey as requested by the Foundation should be undertaken in South Dakota and that a suitable questionnaire be submitted to representative physicians engaged in obstetrics.

W. A. Geib, M.D.
D. H. Breit, M.D.
C. L. Vogeley, M.D.

REPORT OF THE COMMITTEE ON THE EAST RIVER CRIPPLED CHILDRENS HOSPITAL AND SCHOOL

Mr. Speaker and Gentlemen:

I was delegated by the chairman of the Advisory Committee of the East River Crippled Childrens Hospital and School to report the functions of that committee.

The first meeting of the committee was on April 6, 1951. The committee was organized with Guy Van Demark as chairman; McGreevy, vice-chairman; Don Manning, secretary; and members Ihle, Erickson, Saxton, Alway, Karlins, and Tank.

It must be understood that this project is en-

tirely in lay hands, and those in charge are both upright and sincere gentlemen, who, without doubt have the crippled children's interests at heart, and our committee only acts in an advisory capacity.

The amount of money pledged was approximately \$550,000, of which all but about \$75,000 has been collected. Since the time of the pledges the money has inflated and the building has consequently deflated to about one-half the planned capacity. It will maintain thirty in-patients and thirty out-patients. It is primarily a school with all eight grades functioning in rural school fashion. There will be physiotherapy, some orthopedic procedure, limited laboratory procedure and necessary incidental medical treatment.

As you can readily see from the limited number of patients, and from the fact that the policy of the institution will be more of a school than a hospital it will be necessary to limit the entrants to children who have a good chance of physical recovery and have a normal mental capacity.

The second meeting of the committee was held on May 12, 1951. We decided that about three teams, consisting of a psychiatrist, an orthopedist, an eye-ear-nose and throat man, and a pediatrician, should be set up as a hospital admittance board. It was also decided that there be appointed by the president of each district society, a physician or physicians for the purpose of screening the children before they are sent to the hospital admittance board.

I wish to impress upon you at this point that the physicians of Sioux Falls are unselfish in this project and will work entirely with the home physician in every manner, and I feel sure that they appreciate that it was only through the co-operation of the entire eastern South Dakota area that this very needed project was obtained.

On May 12, 1951 I went out to see the building which is located on West 26th Street, just south of the Veterans Administration Hospital group in a very beautiful location. The walls were all constructed, but at that time it was not covered. So it is our feeling that it will not be opened until late fall or early spring.

Myron C. Tank
Brookings, S. D.

REPORT OF THE LEGISLATIVE SUBCOMMITTEE

From the standpoint of the South Dakota State Medical Association, the legislative session of 1951 was very successful. The election of our Executive Secretary, Mr. John Foster, as a representative from Minnehaha County improved our position. The State Medical Society through the Council sponsored five bills, only one of which was defeated.

H.B. 92—Workmen's Compensation law. Liability of Insurance Companies increased to \$300.00 for the physician; \$700.00 for the hospital. It was originally introduced as a no limit bill for surgical and hospital benefits for the workmen but was amended in passage.

S.B. 159—Dog pound law. Dogs and other small animals left in city pounds over five days could be used for research by Department of Health approved schools of higher learning. It was passed.

H.B. 66—Coroners law. Provides that a coroner may order an autopsy on suspicion of wrongful death. It was passed. The previous law was ambiguous in that it only provided for an examination after a request.

H.B. 206—Added a nurse and a pharmacist to the Advisory Council of the State Board of Health replacing lay members. It was passed.

H.B. 361—Concerning who may use the term "doctor." This bill was defeated in the House.

D. A. Gregory, M.D.
M. M. Morrissey, M.D.

REPORT OF THE AUDITING AND APPROPRIATIONS COMMITTEE

The Auditing and Appropriations Committee met in Room 216 of the Alonzo Ward Hotel. The meeting began at 5:45; those present were Drs. Gillis, Morrissey, VanDemark, Gregory, Pankow, Reding, Mayer, and executive secretary Foster.

Dr. Gillis brought the meeting to order and discussed Dr. Mayer's report as Secretary-Treasury. Dr. Gillis moved the report be accepted. Seconded by Dr. Morrissey and carried.

Dr. Morrissey moved that the CPA Audit be accepted. Seconded by Dr. Gillis and carried.

The following budget for next year was discussed and Dr. Morrissey moved that it be accepted. Seconded by Dr. VanDemark and carried. Meeting adjourned at 6:45.

Estimated income	\$23000.00
Dues	\$2000.00
Annual Meeting, etc.	3000.00
Estimated Disbursements	
Secretary	\$ 1200.00
Attorney	300.00
Audit	75.00
Dues & Subscriptions	1000.00
Council & Officers	1200.00
Benevolent Fund	200.00
Annual Meeting	2750.00
Exec. Sec'y—Travel	2000.00
Exec. Sec'y—Salary	8000.00
Office Salaries	2200.00
Office Expense	2000.00
Public Relations	800.00
Reserve Fund	885.00
Balance	\$22610.00
	390.00

F. D. Gillis, M.D.
M. M. Morrissey, M.D.
R. E. VanDeMark, M.D.

REPORT OF THE COUNCILLOR OF THE FIRST DISTRICT

Since June of 1950 the Society has held ten meetings of which nine were scientific and one was a business meeting. Speakers for the scientific meetings were from out of town. The following topics were discussed:

1. "Sternal Smears as an Aid to Blood Dyscrasias"—Dr. Hargroves, Mayo Clinic
2. "Medical Defense Against Atomical Attack"—Dr. G. J. VanHeuvelen, Pierre, S. D.
3. "Diagnosis and Treatment of Skin Diseases of Children"—Dr. Helen Jane Hare, Rapid City, S. D.
4. "The Causes of Hematuria"—Dr. Donald Creevy
5. "Blood Procurement in National Defense"—Dr. G. A. Matson, Minneapolis, Minn.
6. "A Movie on Gastric Resection"—Philip Thorak, M.D.
7. "Common Proctological Diseases Found in the Office"—Dr. Burton Coughlin
8. "Treatment of Common Skin Diseases"—Dr. Elmer Ceder, Minneapolis, Minn.

Dr. L. J. Pankow addressed the members on who is eligible for the 50 year pin, and John C. Foster talked and discussed legislative and business matters.

The district adopted a minimum fee schedule, and a new constitution and By-Laws were drawn up and unanimously accepted by the members.

The meetings were well attended and interest seems to be improving. There are about 35 doctors in our society and the dues are well paid up.

J. D. Alway, M.D.
Councillor, First District
Aberdeen, South Dakota

REPORT OF THE COUNCILLOR OF THE SECOND DISTRICT

Total Members 26
Paid up to date 25
Special Activities for the year:
1. Cooperated with the schools in providing pre-school physical examinations.
2. Carried out immunization program in co-operation with the schools.
3. Participated in diabetic detection drive.
4. Members assisted in publicity for the American Cancer Society.
5. Adopted a set of new and revised by-laws.
Review of Meetings:
May 9, 1950
Members present 17
Guests
Guest speaker Dr. F. Whittich, Minneapolis, Minn., Allergist.
June 6, 1950
Members present 17
Guests 1
Business Meeting
September 5, 1950
Members present 16
Guests 8
Guest Speaker J. F. McNamara, Insurance Underwriter, discussed the role of private insurance in the fight against socialized medicine.
October 3, 1950
Members present 17
Guests 1
Business Meeting and Movies of the 1950 AMA Convention in San Francisco.
November 7, 1950
Members present 17
Guests 1
Guest Speaker, Dr. Donald Slaughter, Dean South Dakota Medical School, "Medical Aspects of Atomic Warfare."
December 5, 1950
Members present 16
Guests 1
Election of Officers:
President: Dr. G. Robert Bartron
Vice-President—Dr. L. J. Armalavage
Secretary-Treasurer: Dr. R. W. Huber
Censors: Dr. M. S. Rousseau
Delegate: Dr. S. J. Walters
Alternate Delegate: Dr. J. H. Crawford, Jr.
January 2, 1951
Members present 16
Business Meeting
February 6, 1951
Members present 14
Business Meeting
March 20, 1951
Members present 15
Business Meeting
(Inclement weather prevented the visit of Dr. Pankow, State President, and guest speaker Dr. King).
April 17, 1951
Members present 21
Guests 5
Visit of State President—Dr. Pankow
Guest Speaker: Dr. King of Sioux Falls, Dermatologist.
C. Rodney Stoltz, M.D.
Councillor Second District
Watertown, South Dakota

REPORT OF THE COUNCILLOR OF THE THIRD DISTRICT

The Third District has twenty-four active paid-up members, one honorary member, and one who is delinquent on his dues: a total of twenty-six members. There are two eligible members in the area, who have not joined.
The Third District has held six regular meetings

during the year, with good attendance. On June 9th, 1950, we met at the General Beadle Hotel in Madison, with fifty-four Auxiliary and District members present, and Dr. Slaughter gave a program on ACTH. On August 10th, 1950, we met at Martinson's Tea Room in Volga, South Dakota, with thirty-eight members present, and the program was by Dr. W. O. Reed on "Physiology of Adrenal Cortex." October 12th, 1950, we met at the Bates Hotel in Brookings, with forty-two members present, and the program was by Dr. Shreves on "Repair and Suture of Nerve in Injuries." On December 14th we met at the Arlington Auditorium with thirty-six present. The program was by Dr. L. M. King, Jr. on "Common Skin Diseases." Then on February 8th, 1951, we met at the Flandreau Indian School Tea Room with forty present. The program was by Dr. M. Smorszczok, on "Medicine Behind the Iron Curtain." On April 12th, 1951, we met at the General Beadle Hotel, Madison, with thirty-five present. The program was by Dr. W. R. Anderson, who spoke on "New Aspects of Treatment of Meningitis."

The Third District has considered a change in its fee schedule, but no definite action has been taken. We are still operating on our old fee schedule.

G. E. Whitson, M.D.
Councillor Third District
Madison, South Dakota

REPORT OF THE COUNCILLOR OF THE FOURTH DISTRICT

The Fourth District Medical Society had 17 paid-up members for the year of 1950. Three regular meetings were held during the year. During the year four regular members have left the district. Also four new members or potential members came into the district. Attempts are being made to increase the activity of the district during 1951, by more regular meetings and to offer more interesting programs.

M. M. Morrissey, M.D.

REPORT OF THE COUNCILLOR OF THE FIFTH DISTRICT

There were four meetings held during the year, one was a scientific meeting, two were business and social and one with the subject of charging the district to include some of the doctors in the Sanborn and Kingsbury counties.

B. T. Lenz, M.D.
Councillor Fifth District
Huron, South Dakota

REPORT OF THE COUNCILLOR OF THE SIXTH DISTRICT

I beg to submit the following report as Councillor of the Sixth District Medical Society.

The year of 1950-51 has shown a marked improvement in the Sixth District Medical Society. We have had five scientific meetings, well attended. A fine feature of this District is our Friday noon meetings every week with cases of scientific and diagnostic interest open to the members of the profession here in this District. These luncheon meetings last 1½ hours and have been an extremely helpful asset to our district. Out-of-town members are invited to attend these Friday noon meetings and bring their interesting cases at that time.

To date we have thirty paid-up members. Four members have not submitted their dues to date.

The group of younger men in the Sixth District have certainly injected a great deal of pep into the meetings. Recently the Sixth District entertained the senior nurses and their escorts of the Methodist State Hospital and St. Joseph's Hospital at a dance at the Country Club. It was extremely hard to tell the entertainers from the entertained.

Pres. Pankow and Sec. Foster met with us on

our March meeting and gave us a very fine meeting.

The Ladies Auxiliary of this District has put forth a great deal of effort and the improvement of that organization is very creditable to the District.

F. D. Gillis, M.D.
Councillor Sixth District
Mitchell, South Dakota

REPORT OF THE COUNCILLOR OF THE SEVENTH DISTRICT

The Seventh District has completed another year of activity. Nine meetings were held during the year. The membership of December 1, 1950, stood at ninety-nine, eleven of whom were members of the Veteran's Administration; two members are honorary. We report with regret the passing of one member during the past year.

A Tumor Clinic has been instituted and meets every Thursday at 10:00 A.M. at the Sioux Falls Public Health Department for consultation. Cases referred in for diagnostic aid are referred back to their family doctors for care.

Present officers of the Seventh District Medical Society are as follows: Dr. Donald H. Breit, President; Dr. John McGreevy, Vice-President; Dr. Don H. Manning, Secretary; Dr. Paul Reagan, Treasurer.

Robert E. VanDemark, M.D.
Councillor Seventh District
Sioux Falls, South Dakota

REPORT OF THE COUNCILLOR OF THE EIGHTH DISTRICT

The Yankton District has 43 members — thirty-six have paid their dues and three have not. There are four honorary members. During the year the District lost two members by death, V. I. Lacy and B. B. Leonard, both of Yankton.

MEETINGS

The fall meeting was held October 12, 1950, at the State Hospital. The members and the auxiliary were dinner guests of Dr. and Mrs. F. J. Haas. The guest speaker was Dr. Sydney E. Johnson, Head of the Department of Radiology, University of Louisville, Louisville, Kentucky. His subject was "Roentgen Therapy of Common Conditions." Following the scientific program, Dr. Louis Pankow, our state president, addressed the society. Dr. Pankow urged the society to have more meetings and also suggested that a board of directors be appointed.

The second meeting was held December 14, 1950, at the Sacred Heart Hospital. The following officers were elected: Dr. E. R. Schwartz, Wakonda, President; Dr. Clark Johnson, Yankton, Vice-President; Dr. T. H. Sattler, Yankton, Secretary and Treasurer. The president and vice-president are to be the Delegates to the annual meeting at Aberdeen in June. The alternates are Dr. F. J. Abts and Dr. R. F. Hubner.

The scientific program was a colored film showing Inguinal Hernioplasty by Dr. C. B. McVay, which was taken at Sacred Heart Hospital.

The third meeting was held on January 25, 1951, at the Sacred Heart Hospital. Dean Slaughter reported on the new organization, the Student AMA, and Dr. A. P. Reding of Marion was appointed Councillor to this organization. The scientific program was "Treatment of Burns" by Dr. Robert Monk, Resident in Surgery at Sacred Heart Hospital, Yankton.

The Fourth Meeting was held on March 15, 1951, in Vermillion. Our Executive Secretary, John C. Foster, was present at this meeting and reported on the action taken by the State Legislature regarding state medical bills. The scientific part of the meeting consisted of a very fine presentation on "Meningitis" by Dr. Warren R. Anderson, Sioux Falls.

In December, 1950, the Yankton District formed the SIOUXLAND MEDICAL ASSOCIATION to fight socialized medicine on a regional level. A group of 25 professional men contributed \$750.00 to undertake an Educational Promotion Program on radio station WNAX — "AMERICANS SPEAK UP!" Another \$800.00 for advertising was obtained through the interest of the regional group of doctors and the other allied professional men.

REPORT OF THE COUNCILLOR OF THE NINTH DISTRICT

The Ninth or Black Hills District of the South Dakota State Medical Association held five meetings during this past year. We have meetings regularly four times a year but this year had one extra enjoyable meeting at Sanator. It is our hope to have six meetings this coming year and to bring into more active participation of our district of affairs the groups of physicians in the Southern Hills.

Our membership here totals about 55 and the district is becoming increasingly more active. We feel we have had a reasonably good year and expect a better one next year.

A. A. Lampert, M.D.
Councillor Ninth District
Rapid City, South Dakota

REPORT OF THE COUNCILLOR OF THE TENTH DISTRICT

The Tenth District organized during the year 1950 and elected a president, Dr. R. K. Morgan, and a secretary, Dr. J. E. Studenberg. One meeting was held at which the Executive Secretary discussed some of the local problems of the district.

R. J. Quinn, M.D.
Councillor Tenth District
Burke, South Dakota

REPORT OF THE COUNCILLOR OF THE ELEVENTH DISTRICT

Again we have had a very inactive year in the Eleventh District. There are ten paid-up members in the district with Drs. B. P. Nolan and Oskars Zeidaks having joined this year. There are two other doctors in the district who are eligible for membership.

There have been no meetings and no officers elected this year.

A. W. Spiry, M.D.
Councillor, 11th District

On April 22nd the 19th broadcast of the current series of AMERICAN'S, SPEAK UP!, was given. This was the last of the series. Another series of broadcasts is being planned for next fall.

A. P. Reding, M.D.
Councillor Eighth District
Marion, South Dakota

REPORT OF THE COUNCILLOR OF THE TWELFTH DISTRICT

President—Harry Brauer, M.D., Sisseton
Vice-Pres.—Joseph Lovering, M.D., Webster
Secretary—Dagfin Lie, M.D., Webster
Delegate—Kurt Tauber, M.D., Milbank
Alternate—W. T. Judge, M.D., Milbank
Councillor—F. F. Pfister, M.D., Webster

Number active members	13
Honorary	2
Total Membership	15
1951 Members Paid	6

Four meetings were held alternating between Sisseton, Milbank and Webster. Instructed delegate to vote against re-districting of the South Dakota State Medical Association.

Resolution of Condolence to family of the late P. D. Peabody, Sr., M.D., Webster, Past President of the State Medical Association. Support pledged to David A. Gregory, M.D., President-Elect of the

South Dakota State Medical Association.

New members moved into the district since the last report were Dr. Walter C. Brinkman, M.D., Waubay; and Joseph A. Jacotel, M.D., Milbank. Faris F. Pfister, M.D. Councillor Twelfth District Webster, South Dakota

COUNCIL MEETING

Alonzo Ward Hotel, Aberdeen

June 2, 1951

Present, Drs. Pankow, Gregory, Jernstrom, Mayer, Brown, Whitson, Alway, Stoltz, Morrissey, Lenz, Gillis, VanDemark, Reding, Lampert, Quinn, Spiry and Pfister, and exec. sec'y Foster.

Dr. Pfister moved that the minutes of the last meeting be dispensed with because they had been published in the March Journal. Seconded by Dr. Stoltz and carried.

Suggested report of the Council for the year read by Dr. Whitson. Dr. Gillis moved the report be adopted. Seconded by Dr. Quinn, carried.

Dr. Gillis read the report of the Auditing & Appropriations Committee. Dr. Gillis moved adoption of the report, seconded by Dr. Stoltz, carried.

REPORTS OF OFFICERS

Reports were before the Councillors in written form. Comments were made by the Councillors and officers on their own reports.

COMMITTEE REPORTS

Reports were before the Councillors in written form. A discussion on the reports followed.

COMMITTEE ON PUBLIC POLICY

AND LEGISLATION

Dr. Pfister moved that the executive secretary be allowed to continue as a candidate for the legislature if he sees fit. Seconded by Dr. Brown, carried.

COMMITTEE ON PUBLICATIONS

Dr. Stoltz moved approval of recommendation to give Honorary Members the Journal at no extra cost. Seconded by Dr. Gillis and carried.

LIASON COMMITTEE WITH STATE BOARD OF HEALTH

Dr. Jernstrom discussed suggestions of the committee. Dr. Whitson ruled that committee reports should be initially acted upon by the House of Delegates.

Discussion of hospital standardization report was made as addendum to the committee on Medical Education and Hospitals.

Discussion of attorney's position with the Association. Dr. Pankow moved council discontinue employment of an attorney on a retainer basis. Seconded by Dr. Stoltz. Motion was lost.

Dr. Stoltz moved that the executive committee take up the matter with Goldsmith and report back to the Council at the September meeting. Seconded by Dr. Pankow, carried.

The report of the Committee on Radio Broadcasts was read and then discussed. Objection was made to the name of Sioux-Land Medical Society, sponsored by the Yankton District Society, and a suggestion was made that the name be changed to Sioux-Land Broadcasting Society or something similar.

Dr. Gillis moved the meeting adjourn, seconded by Dr. Morrissey, carried.

Adjourned at 10:00 P. M.

COUNCIL MEETING

ALONZO WARD HOTEL ABERDEEN

June 5, 1951

Dr. Gregory called the Council to order at 9:10 p. m.

Those present were Drs. Davidson, Morrissey, Quinn, Jernstrom, Lampert, Alway, VanDemark, Spiry, Pankow, Pfister, Brown, Stoltz, Gillis, Reding, Gregory, Mayer and exec. sec'y Foster.

Dr. Mayer read the minutes of the last council

meeting. Dr. Jernstrom moved that the minutes be accepted as read. Seconded by Dr. Reding and carried.

Dr. Alway nominated Dr. VanDemark as Chairman of the Council. Seconded by Dr. Reding. Dr. Davidson moved that nominations cease. Dr. Jernstrom seconded the motion. Dr. Davidson moved that the secretary be instructed to cast a unanimous ballot for Dr. VanDemark. Motion seconded by Dr. Pfister and carried.

Dr. Pankow moved that the same committee on Auditing and Appropriations be re-appointed. Seconded by Dr. Alway, carried.

Dr. Stoltz moved that the Council be instructed to present to the Temporary Grievance Committee to continue functioning through 1951-52 and be recommended to bring in a suggested amendment to the By-Laws at the next meeting. Seconded by Dr. Jernstrom and carried.

Dr. Davidson moved that the present Journal staff be maintained. Seconded by Dr. Reding and carried.

Dr. Mayer offered his resignation as secretary of the State Medical Association. Dr. Reding made the motion to accept Dr. Mayer's resignation. Seconded by Dr. Morrissey and carried.

Dr. Pfister moved that the immediate past president occupy the office of sec'y-treas. Seconded by Dr. Jernstrom, carried.

Dr. Pankow moved that the office of secretary-treasurer by without pay and that only the necessary expenses be remunerated.

A discussion on the replacement of Dr. Sherwood on the Board of Medical and Osteopathic Examiners was held. Dr. Brown moved that the names of Dr. Pankow and Dr. Davidson be submitted to the Governor. Seconded by Dr. Jernstrom and carried.

A discussion on holding two or three day scientific sessions was then held. No action was taken.

Dr. Reding moved that the exec. sec'y be rehired. Seconded by Dr. Pfister and carried.

Meeting adjourned at 10:30 p. m.

HOUSE OF DELEGATES MEETING BALLROOM, ALONZO WARD HOTEL

June 3, 1951

The 70th Annual Session of the House of Delegates of the South Dakota State Medical Association was called to order at 1:10 P. M. by Association President, Dr. L. J. Pankow.

Dr. Pankow then turned the meeting over to Dr. Brown, Speaker of the House.

Dr. Mayer called the roll. Those present were: Pankow, Gregory, Jernstrom, Mayer, Foster, Brown, Alway, Stoltz, Whitson, Morrissey, Lenz, Gillis, VanDemark, Rodine, Aberdeen; Scallin, Redfield; Magni Davidson, Brookings; Lampert, Quinn, Spiry, Pfister, Huron — Delegates Rodine, Scallin, Magni Davidson, C. E. Sherwood, Madison; D. C. Austin, Brookings; L. C. Askwig, Pierre — Adams, Huron — Gillis, Mitchellburg, Mitchell; C. J. McDonald, Sioux Falls; J. A. Kittelson, Sioux Falls; F. C. Kohlmeyer, Sioux Falls; E. R. Schwartz, Wakonda; W. A. Geib, Rapid City; H. J. Grau, Rapid City; W. L. Meyer, Sanator; — Quorum present. Minutes dispensed with — published — President Pankow announced appointment of Com. on Nominations — C. J. McDonald, Sioux Falls, Chairman — Rodine, Aberdeen — Stoltz, Watertown — Austin, Madison — askwig, Pierre — Adams, Huron — Gillis, Mitchell — McDonald, Sioux Falls — Reding, Yankton Dist. — Meyer, Black Hills — Quinn, Rosebud — Totten, Northwest — Pfister, Whetstone Valley.

A quorum was present.

Dr. Lampert moved that reading of the minutes of the last meeting be dispensed with because they had been published in the Journal. Seconded by Dr. Schwartz and carried.

Dr. Pankow then named the following delegates

to the nominating committee: Dr. J. C. Rodine, Aberdeen; Dr. C. R. Stoltz, Watertown; Dr. D. C. Austin, Brookings; L. C. Askwig, Pierre; Dr. H. P. Adams, Huron; Dr. F. D. Gillis, Mitchell; Dr. C. J. McDonald, Sioux Falls; Dr. A. P. Reding, Marion; Dr. W. L. Meyer, Sanator; Dr. R. J. Quinn, Burke; Dr. F. C. Totten, Lemmon; Dr. F. F. Pfister, Webster. Dr. McDonald was named chairman of the committee.

Dr. Brown then said a few words as Speaker of the House. He asked that the nominating committee consider someone else for Speaker of the House for the coming year. He discussed the rules of procedure of the House.

Appointments of reference committees were made by Dr. Brown: Committee on Credentials — Dr. Meyer, chr.; Dr. Totten, Dr. Kohlmeyer.

#1 Committee on Reports of Officers and Councilors — Dr. Askwig, chr.; Dr. Kittelson, Dr. Adams.

#2 Committee on Amendments to the Constitution and By-Laws — Dr. Davidson, chr., Dr. Lenz, Dr. Spiry.

#3 Committee on Resolutions and Memorials — Dr. Scallin, chr., Dr. Manning, Dr. Walters.

#4 Committee on reports of standing committees — Dr. Schwartz, chr., Dr. Gib, Dr. Stoltz.

#5 Committee on Special Committees and Misc. Business — Dr. VanDemark, chr., Dr. J. C. Rodine, Dr. Vonburg.

Tellers — Dr. Grau, Dr. Hubner, Dr. Moran.

Report of officers:

Report of the President—published—referred to Committee #1

Report of the President-elect—published—referred to Committee #1

Report of the Vice-President—read by Dr. Jernstrom—referred to Committee #1

Report of the Sec'y-Treas.—published—referred to Committee #1

Report of the Delegate to the AMA—published—referred to Committee #1

Report of the Chairman of the Council—read by Dr. Whitson—Committee #1

Report of the Councillor from Dist. #1—published—Committee #1

Report of the Councillor from Dist. #2—published—Committee #1

Report of the Councillor from Dist. #3—published—Committee #1

Report of the Councillor from Dist. #4—read by Dr. Morrissey—Committee #1

Report of the Councillor from Dist. #5—read by Dr. Lenz—Committee #1

Report of the Councillor from Dist. #6—read by Dr. Gillis—Committee #1

Report of the Councillor from Dist. #7—published—Committee #1

Report of the Councillor from Dist. #8—published—Committee #1

Report of the Councillor from Dist. #9—published—Committee #1

Report of the Councillor from Dist. #10—published—Committee #1

Report of the Councillor from Dist. #11—read by Dr. Siry—Committee #1

Report of the Councillor from Dist. #12—published—Committee #1

Report of the Vice-President—read by Dr. Jernstrom—Committee #1

REPORTS OF STANDING COMMITTEES

Scientific Work—published—referred to Committee #4

Public Policy & Legislation—published—referred to Committee #4

Publications—published—referred to Committee #4

Medical Defense—published—referred to Committee #4

Medical Education & Hospitals—published—referred to Committee #4

Medical Economics—published—referred to Committee #4

Necrology—(amendment) Published—referred to Committee #4

Public Health—no report

Subcommittee on Cancer—published—referred to Committee #4

Subcommittee on TB—published—referred to Committee #4

Subcommittee on Maternal & Child Welfare—published—Committee #4

Diabetes—no report

Mental Health—published—referred to Committee #4

Rheumatic Fever & Heart Disease—no report

Medical Benevolence—published—Committee #4

Executive Committee—read by Dr. Pankow—reference Committee #4

Grievance Committee—read by Mr. Foster—reference Committee #4

Radio Broadcast—published—reference Committee #5

Editorial Committee—published—Committee #5

Medical Licensure—published—Committee #5

Vet. Adm. & Medical Service—published—Committee #5

Spafford Memorial Fund—no report

Prepayment & Insurance—published—Committee #5

Rural Medical Service—published—Committee #5

Medical School Affairs (added supplement) published—Committee #5

Nursing Training—published—Committee #5

Workmen's Comp.—published—Committee #5 (VanDemark commended Schwartz and Dr. Pankow)

Liaison Committee with St. Board of Health—published—Committee #6

Adv. Committee to Eastern Crippled Children's Hospital & Home—read by Dr. Tank—Committee #5

Nat'l Legislation—no report

Auditing Committee—read by Dr. Gillis—Committee #4

There was no old business.

New Business

Dr. Pankow moved the following amendment to the Constitution & By-Laws of this Association, Chapter 7, "Committees," Section 1, that the committee on Medical School Affairs be added to the list of standing committees. Seconded by Pfister.

Dr. Stoltz moved that the amendment be referred to the committee on Amendments to the Constitution and By-Laws and be brought up for consideration by the House of Delegates. Dr. Reding seconded, carried.

Dr. Geib moved the House confer honorary membership on Dr. E. H. Brock and Dr. A. S. Jackson. Dr. Meyer seconded the motion, carried. Dr. Spiry moved that Dr. W. A. George of Selby be made an honorary member; seconded by Dr. Jernstrom, carried.

Dr. C. J. McDonald invited the Medical Association to hold their next meeting in Sioux Falls. This was referred to the committee on nominations. Dr. Alway moved that Dr. J. D. Whiteside of Aberdeen be made an honorary member, seconded by Dr. Morrissey and carried.

Dr. Pankow discussed the Past-presidents Certificates and the Distinguished Service Award. Dr. Pankow moved that the rules be suspended and action be taken on the Past-Presidents award immediately. Seconded by Dr. Stoltz, carried. Dr. Pankow moved that it be the policy of this Association to award annually a certificate of attainment to the past presidents and that at this time action be retroactive to include all living past presidents. Motion seconded by Dr. Whitson, carried.

Dr. Pankow moved that a Distinguished Service Award be inaugurated. This report was referred to the Reference Committee on Special Committees

and Misc. Business.

Dr. Gregory moved that a 15 minute recess be taken at which time the Reference Committee on Special Committees and Misc. Business should take up the motion on Distinguished Service Awards. Seconded by Dr. Pankow, carried. Recess called.

The meeting resumed at 3:10 P. M.

Dr. VanDemark read the report of the Reference Committee on Special Committees and Misc. Business as amended. Dr. Pankow moved the adoption of the report of the reference committee. Seconded by Dr. McDonald, and carried.

Dr. Gregory presented a resolution on a Schedule of fees for care of indigent Indians. Referred to reference committee #5.

Announcements were made by exec. sec'y Foster and Sec'y Mayer. Dr. Gregory moved that the meeting adjourn. Seconded by Dr. Stoltz, carried. Adjourned at 3:25 P. M.

SECOND SESSION HOUSE OF DELEGATES

Alonzo Ward Hotel, Aberdeen

June 5th, 1951

Dr. Brown called the second session of the House of Delegates to order at 8:10 p. m. The first order of business was the roll call. Those present were: Pankow, Gregory, Jernstrom, Mayer, Foster, Brown, Alway, Stoltz, Whitson, Davidson, Morrissey, Lenz, Buchanan, Gillis, VanDemark, Reding, Lampert, Quinn, Spiry, Pfister, Saxton, Rodine, Scallin, Walters, Austin, Askwig, Leigh, Vonburg, McDonald, Kitteuson, Myrabo, Schwartz, Geib, Grau.

A quorum was present.

Dr. Mayer read the minutes of the last house meeting and Dr. Geib moved that the minutes be accepted as read. Seconded by Dr. Schwartz and carried.

Dr. McDonald read the report of the Nominating Committee. Dr. McDonald moved that the report be accepted as a whole, seconded by Dr. Stoltz and carried.

Dr. Totten read the report of the Committee on Credentials and moved that be it adopted as a whole, seconded by Dr. Stoltz and carried.

Dr. Gregory gave a brief talk as president elect.

Dr. Askwig read the report of the Reference Committee on Officers and Councillors. Dr. Askwig moved that the report be adopted as a whole, seconded by Dr. Davidson and carried.

Dr. Davidson read the report of the Reference Committee on Constitution and By-Laws and after much discussion moved that the report be accepted as a whole. Seconded by Dr. McDonald and carried.

Dr. Schwartz read the report of the Reference Committee on Standing Committees and moved that the report be adopted as a whole. Seconded by Dr. Kittelson, carried.

Dr. VanDemark read the report of the Reference Committee on Special Committees and Misc. Business. Dr. Pankow moved that in the report of the radio broadcast committee the words "the most in the state" be crossed out. Motion lost for lack of a second. Dr. Pankow moved to amend the report of the Pre-Payment and Insurance Committee by adding the words "The House of Delegates urges the committee to seek to obtain an arrangement policy with insurance companies which will more nearly provide medical care and hospital care for the low income group and in accord with the aims of the AMA and to offset socialized medicine. Seconded by Dr. Kittelson and carried.

Dr. VanDemark moved that the amended report be accepted. Seconded by Dr. Gregory and carried. Dr. VanDemark moved that the report as a whole and as adopted be accepted. Seconded by Dr. Gregory and carried.

Dr. Scallin read the report of the Reference Committee on Resolutions and Memorials. Dr.

Gregory moved that the same paragraphs be used in commending the Mayor and City officials of Aberdeen. Seconded by Dr. McDonald and carried. Dr. Scallin moved that the report of the committee be adopted as amended. Seconded by Dr. McDonald and carried.

No new business.

Announcements were made by Foster.

Dr. Pankow moved that the incoming president through proper committees pursue further the question of re-districting the State of South Dakota and report back at the next Council Meeting. Seconded by Dr. Totten and carried.

Dr. Brown express his thanks and appreciation for the cooperation given him by the reference committees on the reports.

Dr. Pankow gave a short talk and expressed his desire for the continuation of the president's page and in support of the Medical School Endowment.

Dr. Pfister moved that the assembly give thanks to Dr. Brown, Speaker of the House, for his effective dispatch of the business. Seconded by Dr. Pankow, carried.

Dr. Totten moved that the meeting adjourn. Seconded by Dr. Pfister, carried. Meeting adjourned at 9:00 p. m.

REPORT OF REFERENCE COMMITTEE OFFICERS AND COUNCILLORS

Presidents Report:

Recommend acceptance of this report.

President-Elect:

Recommend acceptance of this report.

Vice-President:

Recommend acceptance of this report.

Secretary:

Recommend acceptance of this report less financial statement which is the province of another committee.

Executive-Secretary:

Recommend acceptance of this report.

Delegate to AMA:

Recommend acceptance of this report.

Report of the Council:

Recommend acceptance of this report.

Report of District Councillors:

Recommend acceptance of these reports.

John Kittelson

H. P. Adams

L. C. Askwig

REPORT OF THE COMMITTEE ON CREDENTIALS

Mr. Speaker, Members of the House of Delegates: The Committee on Credentials wishes to report the following:

Number of members registered	162
Number of guests registered	89
Number of exhibitors registered	64
Number of ladies auxiliary registered	85
TOTAL	394
W. L. Meyer, Chairman	
F. C. Totten	

REPORT OF THE REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

The Committee on Amendments to the Constitution and By-Laws has studied the resolution presented by Dr. Slaughter, Chairman of the Committee on Medical School Affairs, as follows: Your Committee on Medical School Affairs respectfully requests that the By-Laws be changed so that the House of Delegates of the South Dakota State Medical Association may make this a standing instead of a special committee. This committee agrees with the intent of the resolution and moves its adoption.

To implement the intent of the resolution, the committee offers the following amendments to the By-Laws:

(1) that CHAPTER VII — COMMITTEES —

SECTION I be amended by deleting the words "Committee on Medical Education and Hospitals" and substituting therefore the words "Committee on Medical School Affairs, Medical Education and Hospitals." I move the adoption of this portion of the report.

(2) that CHAPTER VII — COMMITTEES — SECTION VI be amended by adding the following: "The purpose of this committee also shall be to give aid, comfort and advice to our Medical School in South Dakota. The Committee on Medical School Affairs shall consist of six members, appointed for three years each. Two members of this committee shall be appointed annually by the president. At this session two members of this committee shall be appointed for a period of three years, two each for two years, and two each for one year." I move the adoption of this report.

Magni Davidson, Chairman
B. T. Lenz
A. W. Spiry

REPORT OF THE REFERENCE COMMITTEE ON RESOLUTIONS AND MEMORIALS

WHEREAS, the Aberdeen doctors have made such detailed arrangements that have contributed in a large measure to the pleasantness and success of the 70th Annual Meeting of the South Dakota State Medical Association.

BE IT RESOLVED, that the South Dakota State Medical Association extend its thanks and appreciation to the local doctors of Aberdeen who have seen to it that the facilities of Aberdeen were at our disposal.

WHEREAS, the Management of the Alonzo Ward and Sherman Hotels have been most cooperative in providing facilities and making arrangements for the success of the 70th Annual Meeting of the South Dakota State Medical Association,

BE IT RESOLVED, that the said Medical Association extend its thanks and appreciation to the said hotels and their managers.

WHEREAS, the Country Club of Aberdeen in providing room and giving freely of their facilities for golf, stag party and in arranging and having the 70th Annual banquet of our State Medical Association has contributed much to the success of our meeting.

BE IT RESOLVED, that the Medical Association extend its sincere thanks to the Country Club.

WHEREAS, the Chamber of Commerce of the City of Aberdeen has been most cooperative in providing facilities and making arrangements for the success of the 70th Annual Meeting of the South Dakota State Medical Association.

BE IT RESOLVED, that the Medical Association extend their thanks to the Chamber of Commerce, its manager, Mr. Arthur Cahow, and to all others in assisting the work and preparation for the meeting.

WHEREAS, the Aberdeen American News has been most cooperative in presenting to the public news of the 70th Annual Meeting of the South Dakota State Medical Association,

BE IT RESOLVED, that the said Medical Association extend its sincere thanks to the Aberdeen American News and its editor, Mr. Henry Schmidt, and staff.

WHEREAS, the druggists of Aberdeen have been most cooperative and have contributed much toward making the 70th Annual Meeting of the South Dakota State Medical Association a pleasant one.

BE IT RESOLVED, that said Medical Association extend its sincere thanks to the druggists of Aberdeen.

Resolution Mayor and City Officials

P. R. Scallin
S. J. Walters
D. H. Manning

REPORT OF THE REFERENCE COMMITTEE ON STANDING COMMITTEES

This committee has reviewed the report of the Committee on Scientific Work and commends the committee on the excellent selection of their speakers for this meeting.

The report of the Committee on Public Policy and Legislation has been reviewed and this committee urges its adoption.

The Standing Committee has reviewed the report of the committee on Publications and urges the adoption of this report.

The committee recommends the adoption of the report of the Committee on Medical Defense.

The Report of the Committee on Medical Education and Hospitals has been reviewed, in regard the report on federal aid to medical education this committee urges the adoption of this portion of this report. In regard to the second portion of this report which pertains to hospital staff membership for physicians not members of District Medical Society and of the State Medical Association, this committee feels that the prerequisite for membership on a hospital staff should be qualification for membership in the district and State Medical Association and actual membership should be encouraged. In regard to staff membership for rural physicians, this committee urges the adoption of this report.

The Committee recommends the adoption of the report of the committee on Necrology as amended.

The Committee urges the adoption of the Report on Public Health.

The Committee recommends the adoption of the Report of the Subcommittees on Tuberculosis, Cancer and Maternal and Child Welfare.

The Committee urges the adoption of the report of the Committee on Mental Health.

The Committee recommends the approval of the Report of the Committee on Medical Benevolence.

The Committee urges the adoption of the Report of the Committee on Auditing and Appropriations.

The Committee urges the adoption of the Report of the Grievance Committee.

The Committee urges the adoption of the Report of the Executive Committee.

E. R. Schwartz, Chairman
C. R. Stoltz
Wayne Geib

REPORT OF THE REFERENCE COMMITTEE ON SPECIAL COMMITTEES AND MISCELLANEOUS BUSINESS

Report #1. Report of the Advisory Committee of the East River Crippled Children's Hospital and School. It is recommended that the report be accepted.

Report #2. The Committee recommends (1) passage of the resolution on indigent Indians introduced by Dr. Gregory. (2) referral of the passed resolution to the committee on Medical Economics for the exact fee schedule with the request that the committee on Medical Economics report back to the Council at their fall meeting. A fee schedule drawn up by the Medical Economics Committee, North Dakota State Medical Association, is submitted for consideration by the committee. (3) That the Council be empowered to act upon the recommendation of the committee.

Report #3. Report of the Committee on Radio Broadcast. It is recommended that the report be accepted with special commendation to the Yankton group for their outstanding fight against socialized medicine and with request for possible re-naming of the project.

Report #4. Report of the Editorial Committee. It is recommended that the report be accepted.

Report #5. Report of the Committee on Medical Licensure. Recommended that the report be accepted.

Report #6. Report of the committee on Veterans' Administration and Military Affairs. Recommend that the report be accepted.

Report #7. Report of the Committee on Prepayment Insurance Plans. It is recommended that the report be accepted. It is the opinion of the present committee that the Committee on Prepayment and Insurance Plans is undoubtedly one of the most important committees in the Medical Society. Few will deny that without insurance or prepayment plans we would now have socialized medicine. Dissatisfaction and lack of protection of any approved plan will reflect directly on the Medical Society and ultimately result in socialization of our profession. The cooperation, comments or suggestions from the House of Delegates as to any improvement of this insurance program would seem in order.

Report #8. Report of the Committee on Rural Medical Service. Recommends that the report be accepted and that the executive secretary be requested to mail the results of the survey in pamphlet form to all member physicians.

Report #9. Report of the committee on Medical School Affairs. Recommend that the report be accepted.

Report #10. Committee on Nursing Training. Recommend that the report be accepted.

Report #11. Report of the Committee on Workmen's Compensation. Recommend that the report be accepted.

Report #12. Report of the Liason Committee With State Department of Health, Division Laboratories. The committee has met with the pathologist and Director of the State Health Laboratories and recommends the following changes in the report. "Section 1, Serological test for syphilis evaluation studies. The State Department of Health conducts yearly evaluation studies of all laboratories performing serological tests for syphilis. Lack of finance, personnel and sources of materials do not permit monthly evaluation studies. In certain instances more than one laboratory or individual in a city may be permitted to perform premarital tests for syphilis only by mutual agreement of the Director of the State Health Laboratories and the approved pathologist in charge of the local laboratory." The Committee recommends adoption of the report as amended.

Report #13. Report of the Legislature Subcommittee. Recommends that the report be accepted.

R. E. VanDemark, Chairman
J. C. Rodine
V. R. Vonburg

The reference committee on Special Committees and Miscellaneous Business recommends that the motion on establishment of a distinguished service award be amended to read as follows:

The South Dakota State Medical Association hereby establishes a distinguished service award which may be presented to one or more members of the Association in recognition of outstanding service to the Association and the profession. Said award winners shall be selected by the Executive Committee prior to the Annual Banquet of the Association.

R. E. VanDemark, M.D.
J. C. Rodine, M.D.

INTRODUCED BY GREGORY, MILBANK

Recognizing a change in policy of the Bureau of Indian Affairs, to utilize private physicians whenever possible, on a fee for service basis, for the care of indigent Indians. Be it resolved that this Association establish a schedule of fees for the care of indigent Indians.

REPORT OF THE NOMINATING COMMITTEE

The Nominating Committee wishes to place in nomination for president Dr. D. A. Gregory, and

moves the adoption of this portion of the report.

For President-elect the committee nominates Dr. R. E. Jernstrom, and moves the adoption of this portion of the report.

For vice-president the committee nominates Dr. R. G. Mayer and moves the adoption of this portion of the report.

For speaker of the house the committee nominates Dr. A. P. Peeke, and moves for adoption of this portion of the report.

For Councillor from the Third District the committee nominates Dr. Magni Davidson and moves the adoption of this portion of the report.

For Councillor from the 5th District the committee nominates Dr. R. A. Buchanan and moves the adoption of this portion of the report.

For Councillor from the 6th district the committee nominates Dr. F. D. Gillis and moves the adoption of this portion of the report.

For Councillor from the 7th district the committee nominates Dr. R. E. VanDemark and moves the adoption of this portion of the report.

The Committee recommends that the next meeting be held in Sioux Falls.

C. J. McDonald, Chr.

ANNOUNCEMENT

Publication of the PROCEEDINGS: FIRST RESEARCH CONFERENCE ON PSYCHOSURGERY has been announced by the National Institute of Mental Health, Public Health Service, Federal Security Agency. The research conference group was established upon the recommendation made by the National Advisory Mental Health Council at its December 1948 meeting. The Council believed that it would be useful to set up such a group to conduct three annual conferences for the exchange of information and the development of plans for research in the field of lobotomy.

The first Research Conference on Psychosurgery met in New York on November 17-18, 1949, under the chairmanship of Dr. Fred Mettler, Columbia University, to discuss **Criteria for Selection of Psychotic Patients for Psychosurgery**. The Conference, supported by a three-year grant from the National Institute of Mental Health, comprised 23 persons representing psychiatry, psychology, neurology, neurosurgery, and other related professional groups.

The PROCEEDINGS also contains a report of the survey conducted by the National Institute of Mental Health in 1949 on the extent to which psychosurgery procedures are being used in mental hospitals, and also the

(Continued on Page 220)

South Dakota Medical Association Roster, 1951

Membership by Districts

ABERDEEN DISTRICT No. 1

Alway, J. D. Aberdeen
 Berbos, J. N., M.M. Aberdeen
 Bloemendaal, G. J. Ipswich
 Brenckle, J. F. Mellette
 Bunker, Paul Aberdeen
 Calene, J. L. Aberdeen
 Cooley, F. H. Aberdeen
 Currie, K. P. Britton
 Damm, W. P. Redfield
 Drissen, E. M. Britton
 Eckrich, J. A. Aberdeen
 *Elward, L. R. Doland
 Gelber, M. R. Aberdeen
 Gorder, W., M.M. Aberdeen
 Graff, L. W. Britton
 *Jackson, E. B. Aberdeen

Keegan, Agnes Aberdeen
 King, B. F. Aberdeen
 King, H. I. Aberdeen
 King, Owen Aberdeen
 McCarthy, P. V. Aberdeen
 McIntosh, G. F. Eureka
 Marvin, T. R. Faulkton
 Martyn, W. E. Aberdeen
 Mayer, R. G. Aberdeen
 Miller, A. J. Aberdeen
 Murdy, B. C. Aberdeen
 Murdy, Carson Aberdeen
 Murdy, Robert Aberdeen
 Nelson, L. A. Faulkton
 Perry, E. J. Redfield

Pittenger, E. A. Aberdeen
 Ranney, T. P. Aberdeen
 Rodine, John Aberdeen
 Rosenberger, H. P. Aberdeen
 Rudolph, E. A. Aberdeen
 Sanders, M. E. Redfield
 Scallin, P. R. Redfield
 Schuchardt, I. L. Aberdeen
 Steele, G. H. Aberdeen
 Van Sandt, M. M. Aberdeen
 Voge, C. L. Aberdeen
 Waldorf, C. E. Redfield
 *Weishaar, C. H. Aberdeen
 Whiteside, J. D. Aberdeen
 Williams, M. F. Conde

WATERTOWN DISTRICT No. 2

Argabrite, J. W. Watertown
 Armalavage, L. J. Watertown
 Auskaps, R. Lake Norden
 Bartron, H. J., Sr. Watertown
 Bartron, H. J., Jr. Clark
 Brown, H. Russell Watertown
 Christianson, A. H. Clark
 Clark, C. J. Watertown
 *Crawford, J. H., Sr. Watertown
 Crawford, J. H., Jr. Watertown
 Fedt, D. N. Watertown

Fershing, Jennings Bryant
 *Hammond, M. J. Watertown
 *Hickman, G. L. Bryant
 Huber, R. W. Watertown
 Kenney, H. T. Watertown
 Kilgard, R. M. Watertown
 Kooperman, M. Estilline
 Larson, M. W. Watertown
 McIntyre, P. S. Bradley
 Magee, W. G. Watertown

Maxwell, R. T. Clear Lake
 Randall, O. S. Watertown
 Reul, T. W. Watertown
 Rousseau, M. C. Watertown
 *Schieb, A. P. Watertown
 Schmidt, Mary Watertown
 Stoltz, C. R. Watertown
 Stransky, John Watertown
 Walters, S. J. Watertown
 Willen, Abner Clear Lake

MADISON-BROOKINGS DISTRICT No. 3

Austin, D. C. Brookings
 Bakalinski, M. Estelline
 Baughman, D. S. Madison
 Baughman, R. C. Madison
 Benjamin, M. B. Flandreau
 Boyd, F. E., Jr. Flandreau
 Davidson, M. Brookings
 Drobinsky, M. Estelline
 Friefeld, S. Brookings

Gulbrandsen, G. H. Brookings
 Henry, R. Brookings
 Hurewitz, M. Colman
 Kershner, C. M. Brookings
 Moyer, L. B. Lake Preston
 Muggly, J. A. Madison
 Patt, W. H. Brookings
 Peeke, A. P. Volga
 Plowman, E. T. Brookings

Ross, R. R. Lake Preston
 Scheller, D. L. Arlington
 Sherwood, C. E. Madison
 Tank, Myron C. Brookings
 Watson, E. S. Brookings
 Westaby, J. R. Madison
 Whitson, G. E. Madison
 Wold, H. R. Madison

PIERRE DISTRICT No. 4

Askwig, L. C. Pierre
 Batt, B. Dupree
 Collins, E. H. Gettysburg
 Cowan, J. T. Pierre
 Curlin, V. Cheyenne Agency
 Fleishman, M. Cheyenne Agency
 Riggs, T. F. Pierre

Gutch, C. F. Nebraska
 Janis, J. B. Hoven
 Martin, H. B. Harrold
 Melin, J. R. Cheyenne Agency
 Morrissey, M. M. Pierre
 Murphy, J. C. Murdo
 *Northrup, F. A. Pierre
 Rimsa, A. Onida

Robbins, C. E. Pierre
 Salladay, I. R. Pierre
 Simon, S. Pierre
 Sundet, N. J. Kadoka
 Swanson, C. L. Pierre
 Takeyamo, G. Y. Cheyenne Agency
 Tesar, C. Midland
 Van Heuvelen, G. J. Pierre

HURON DISTRICT No. 5

Adams, H. P. Huron
 Buchanan, R. A. Huron
 Burman, Guy DeSmet
 Carboneau, Y. H. Huron
 *Class, F. L. Huron
 *Cogswell, M. E. Wolsey
 Dean, Roscoe Wess. Springs
 Gryte, C. F. Huron

Hagin, J. C. Miller
 Hofer, E. A. Huron
 Hohm, Paul Huron
 Hohm, T. A. Huron
 Jacoby, Hans Huron
 Leigh, Fred Huron
 Lenz, B. T. Huron
 Pangburn, M. W. Miller

Saxton, W. H. Huron
 Saylor, H. L., Jr. Huron
 *Saylor, H. L. Huron
 Tschetter, Joseph Huron
 Tschetter, J. S. Huron
 Tschetter, Paul Huron
 *Wood, T. J. Huron
 *Wright, O. R. Huron

MITCHELL DISTRICT No. 6

Auld, C. V. Plankinton
Binder, C. R. Chamberlain
Bobb, E. C. Mitchell
Bobb, C. S. Mitchell
Bollinger, W. Parkston
Delaney, R. J. Mitchell
Delaney, W. A., Sr. Mitchell
Delaney, W. A., Jr. Mitchell
Dick, L. C. Spencer
Fritz, W. H. Mitchell
Gillis, F. Daniels Mitchell
Gillis, Floyd D., Jr. Mitchell

Graham, H. Chamberlain
Holland, L. W. Chamberlain
*Keene, F. F. Wess. Springs
Lewis, H. R. Mitchell
Lloyd, J. H. Mitchell
Mabee, D. R. Mitchell
Mabee, O. J. Mitchell
Moran, C. S. Mitchell
Murphy, J. T. Mitchell
Nelmark, D. R. Mitchell
Price, Mary Armour

Price, Ronald Armour
Rieb, W. G. Parkston
Saylor, Jerome Howard
Shaw, M. R. Tripp
Skogmo, B. R. Mitchell
*Stegeman, S. B. Salem
Tobin, F. J. Mitchell
Tobin, L. W. Mitchell
Tomlinson, Wray Mitchell
Vomburg, V. R. Mitchell
Welbes, M. A. Bridgewater

SIOUX FALLS DISTRICT No. 7

Anderson, W. Sioux Falls
Aspaas, P. K. Dell Rapids
Arneson, W. A. Sioux Falls
Billingsley, P. R. Sioux Falls
*Billion, T. J. Sioux Falls
Billion, T. J., Jr. Sioux Falls
Breit, D. H. Sioux Falls
Burns, E. M. Sioux Falls
Carney, Myrtle California
Chalmers, J. H. Sioux Falls
Clark, J. C. Sioux Falls
Clarke, J. Y. Sioux Falls
Cooper, D. C. Sioux Falls
Cottam, G. I. W. Sioux Falls
Culbertson, R. A. Sioux Falls
Dehli, F. C. Colton
DeVall, F. C. Garretson
Dickinson, J. H. Canistota
Donahoe, J. W. Sioux Falls
Donahoe, R. R. Sioux Falls
Donahoe, S. A. Sioux Falls
Donahoe, W. E. Sioux Falls
Driver, D. R. Sioux Falls
Duimstra, Fred Sioux Falls
Dulaney, C. H. Canton
Eggers, M. W. Sioux Falls
Eirinberg, I. D. Sioux Falls
Eneboe, E. E. Alcester
Erickson, E. G. Sioux Falls
Fiske, R. R. Flandreau
*Gage, E. E. Sioux Falls
Green, C. D. Parker
Green, R. D. Sioux Falls
Greenfield, R. E. Sioux Falls
Greenough, E. E. Sioux Falls

Gregg, J. B. Sioux Falls
Groebner, O. A. Sioux Falls
Grove, A. F. Dell Rapids
Grove, M. S. Sioux Falls
Hage, W. J. Sioux Falls
Harris, M. A. Sioux Falls
Heib, W. E. Marion
Hermanson, J. M. Valley Springs
Hofer, E. J. Freeman
House, R. M. Sioux Falls
*Hummer, H. R. Sioux Falls
Hyden, Anton Sioux Falls
Ihle, C. W., Jr. Sioux Falls
Jones, W. L. Sioux Falls
Keller, S. A. Sioux Falls
Kemper, C. E. Viborg
Kilness, A. Sioux Falls
King, Lyndon, Jr. Sioux Falls
Kittelson, H. O. Sioux Falls
Kittleson, J. A. Sioux Falls
Kohlmeyer, F. C. Sioux Falls
Lamb, Hazel Sioux Falls
Lanam, M. O. Sioux Falls
Larson, C. S. Sioux Falls
Leraan, L. G. Sioux Falls
Lietzke, E. T. Beresford
Lindquist, P. H. Canova
Logan, R. A. Aberdeen
McDonald, C. J. Sioux Falls
McDonnell, J. L. Montrose
McGreevey, E. J. Sioux Falls
McGreevey, J. V. Sioux Falls
McMullen, R. W. Parker
Manning, D. H. Sioux Falls

Maresh, E. R. Sioux Falls
Marturana, F. P. Sioux Falls
Myrabo, A. K. Sioux Falls
Nelson, J. A. Sioux Falls
Nilsson, F. C. Sioux Falls
Ogborn, R. J. Sioux Falls
Opheim, W. L. Sioux Falls
Pankow, L. J. Sioux Falls
Parke, L. L. Canton
Pekelis, F. California
Pullman, N. K. Valley Springs
Quinn, R. H. Sioux Falls
Rayburn, F. W. Sioux Falls
Reagan, P. C. Sioux Falls
Reagan, R. Sioux Falls
Rich, E. L. Sioux Falls
Sercl, William Sioux Falls
Shreves, Howard Sioux Falls
Stahmann, F. S. Sioux Falls
Stern, C. A. Sioux Falls
Stevens, G. A. Sioux Falls
Suckow, E. E. Garretson
Unruh, B. H. Sioux Falls
Vandemark, G. E. Sioux Falls
Vandemark, R. E. Sioux Falls
Vandemark, W. E. Sioux Falls
Van Lier, P. C. Sioux Falls
Volin, H. P. Lennox
Volin, V. V. Sioux Falls
Wessman, N. E. Sioux Falls
Zellhofer, H. W. K. Sioux Falls
Zimmerman, Goldie E. Sioux Falls

YANKTON DISTRICT No. 8

Abts, F. J. Yankton
Andre, H. C. Vermillion
Auld, M. A. Yankton
Baum, O. Yankton
*Beall, L. F. Irene
Blezek, F. M. Tabor
Brown, D. R. Tyndall
Eyres, T. E. Vermillion
Fairbanks, W. H. Vermillion
Flynn, Eugene Pickstown
Glood, D. Viborg
Haas, F. W. Yankton
Hanson, H. F. Vermillion
Hill, J. F. Yankton

*Hohf, J. A. Yankton
*Hohf, S. M. Yankton
Honke, R. W. Wagner
Hubner, R. F. Yankton
Johnson, C. F. Yankton
Jordan, G. T. Vermillion
*Kalayjian, D. S. Parker
Kalda, E. F. Platte
Kaufman, I. I. Freeman
*Keeling, C. M. Springfield
Klima, Herman Yankton
Livingston, R. F. Yankton
McVay, C. B. Yankton
Monk, R. Yankton

Ohlmacher, J. C. Yankton
Ranney, Brooks Yankton
Reding, A. P. Marion
Sattler, T. H. Yankton
Scales, A. B. Pickstown
Schwartz, E. R. Wakonda
Slaughter, D. H. Vermillion
Smith, A. J. Yankton
Stansbury, E. M. Vermillion
Steele, J. P. Yankton
Thompson, W. Vermillion
Williams, D. B. Yankton
Willcockson, T. H. Yankton

BLACK HILLS DISTRICT No. 9

Bailey, J. D. Rapid City
Bailey, S. G. Hot Springs
Baker, C. Belle Fourche
Berkman, D. S. Rapid City
Borgmeyer, H. J. Rapid City

*Brock, E. H. Rapid City
Butler, J. M. Hot Springs
Byrne, J. R. Edgemont
Clark, B. S. Spearfish
Crane, Harold California

D'Arata, E. J. New Underwood
Davidson, H. E. Lead
Davis, J. H. Belle Fourche
Dawley, W. A. Rapid City
Dillon, J. A., M.M. Rapid City

Erickson, J. W. Rapid City
 Fleeger, R. B. Lead
 Geib, Wayne Rapid City
 Grau, H. J. Rapid City
 Hamm, J. N. Sturgis
 Hare, Helen J. Rapid City
 Hare, Lyle Spearfish
 Heideprein, Glen Deadwood
 Heineman, A. A. Wasta
 Howe, F. S. Deadwood
 Holleman, W. W. Rapid City
 *Jackson, A. S. Lead
 *Jackson, R. J. Rapid City
 Jernstrom, Roy E. Rapid City
 Johnson, C. A. Belle Fourche
 Jones, W. E. Sturgis
 Kegaries, D. L. Rapid City
 Kobza, V. V. Rapid City
 Koran, P. H. Rapid City
 Lampert, A. A. Rapid City

Lemley, R. E. Rapid City
 Mattox, N. E. Lead
 Merryman, M. P. Rapid City
 Meyer, W. L. Sanator
 Miller, G. A. Hot Springs
 *Miler, G. H. Spearfish
 Morse, W. E. Rapid City
 Morsman, C. F. Hot Springs
 McCroskey, R. C. Rapid City
 Namminga, S. A. Fort Meade
 Neisius, F. Lead
 Neves, C. A. Hot Springs
 Newby, H. D. Rapid City
 Olson, W. E. Ft. Meade
 Orvedahl, F. W. Hot Springs
 *Owen, N. T. Rapid City
 O'Toole, T. Rapid City
 Pemberton, M. O. Deadwood
 Petsch, K. R. Hot Springs

Radusch, F. J. Rapid City
 Riner, H. L. Hot Springs
 Roper, C. E. Hot Springs
 Rudolph, F. A. Rapid City
 Sackett, R. F. St. Paul
 Saxton, A. J. Rapid City
 Sebring, F. U. Martin
 Semones, A. Lead
 Sherrill, S. F. Belle Fourche
 Smiley, J. C. Deadwood
 Soe, C. A. Hot Springs
 Spain, M. L. Rapid City
 *Stewart, J. L. Spearfish
 Stewart, N. W. Lead
 *Townsend, L. J. Belle Fourche
 Westaby, R. S. Martin
 Williams, F. R. Rapid City
 Yackley, J. V. Rapid City

ROSEBUD DISTRICT No. 10

Clark, C. A. Winner
 Clark, F. J. Gregory
 Mannion, J. E. Gregory

Morgan, R. K. Winner
 Quinn, R. J. Burke

Studenberg, J. E. Winner
 Wilson, R. W. Burke

NORTHWEST DISTRICT No. 11

*George, W. A. Selby
 Jestadt, J. Lemmon
 Lowe, C. E. Mobridge
 Lowe, J. A. Mobridge

Nolan, B. P. Mobridge
 Spiry, A. W. Mobridge
 Steiner, P. K. Lemmon

Torkildson, G. C. McLaughlin
 Totten, F. C. Lemmon
 Zeidak, O. Isabel

WHETSTONE DISTRICT No. 12

Brauer, H. H. Sisseton
 Gregory, D. A. Milbank
 *Hawkins, A. P. Waubay
 *Jacotel, J. A. Milbank
 Johnson, E. A. Milbank

Judge, W. T. Milbank
 Karlins, W. H. Webster
 Lovering, Joseph Webster
 Peabody, J. D., Jr. Sisseton
 Pfister, F. F. Webster

Tauber, K. S. Milbank
 Younker, F. T. Sisseton

*Indicates Honorary Member
 M.M. Indicates Military Member

Roster—South Dakota Medical Association, 1951

Abts, F. J. Yankton
 Adams, H. P. Huron
 Alway, J. D. Aberdeen
 Anderson, W. Sioux Falls
 Andre, H. C. Vermillion
 Argabrite, J. W. Watertown
 Armalavage, L. J. Watertown
 Arneson, W. A. Sioux Falls
 Askwig, L. C. Pierre
 Aspaas, P. K. Dell Rapids
 Auld, C. V. Plankinton
 Auld, M. A. Yankton
 Auskaps, R. Lake Norden
 Austin, D. C. Brookings
 Bailey, J. D. Rapid City
 Bailey, S. G. Hot Springs
 Bakalinsky, M. Estelline
 Baker, C. Belle Fourche
 Bartron, H. J. Watertown
 Bartron, H. J., Jr. Clark
 Batt, B. Dupree
 Baughman, D. S. Madison
 Baughman, R. C. Madison
 Baum, Otto Yankton
 *Beal, L. F. Irene
 Benjamin, M. B. Flandreau
 Berbos, J. N., M.M. Aberdeen
 Berkman, D. S. Rapid City
 Billingsley, P. R. Sioux Falls
 *Billion, T. J. Sioux Falls
 Billion, T. J., Jr. Sioux Falls
 Binder, C. F. Chamberlain

Blezek, F. M. Tabor
 Bloemendaal, G. J. Ipswich
 Bobb, E. C. Mitchell
 *Bobb, C. S. Mitchell
 Bollinger, W. F. Parkston
 Borgmeyer, H. J. Rapid City
 Boyd, F. E. Flandreau
 Brauer, H. H. Sisseton
 Breit, D. H. Sioux Falls
 Brenckle, J. F. Mellette
 Brock, Ernest Rapid City
 Brown, D. R. Tyndall
 Brown, H. Russell, Watertown
 Buchanan, R. A. Huron
 Bunker, P. G. Aberdeen
 Burman, G. E. DeSmet
 Burns, E. M. Sioux Falls
 Butler, J. M. Hot Springs
 Byrne, J. R. Edgemont
 Calene, J. L. Aberdeen
 Carney, Myrtle California
 Chalmers, J. H. Sioux Falls
 Charbonneau, Y. H. Huron
 Christianson, A. H. Clark
 Clark, B. S. Spearfish
 Clark, C. A. Winner
 Clark, C. J. Watertown
 Clark, F. J. Gregory
 Clark, J. C. Sioux Falls
 Clarke, J. Y. Sioux Falls
 *M.M.
 *Class, F. L. Huron

Cogswell, M. E. Wolsey
 Collins, E. H. Gettysburg
 Cooley, F. H. Aberdeen
 Cooper, D. C. Sioux Falls
 Cottam, G. I. W. Sioux Falls
 Cowan, J. T. Pierre
 Crane, H. California
 *Crawford, J. H. Watertown
 Crawford, J. H., Jr. Watertown
 Curlin, V. Cheyenne Agency
 Currie, K. P. Britton
 Culbertson, R. A. Sioux Falls
 Damm, W. P. Redfield
 D'Arata, E. J. New Underwood
 Davidson, H. E. Lead
 Davidson, M. Brookings
 Davis, J. H. Belle Fourche
 Dawley, W. A. Rapid City
 Dean, Roscoe Wess. Springs
 Delhi, H. M. Colton
 Delaney, R. J. Mitchell
 Delaney, W. A. Mitchell
 Delaney, W. A., Jr. Mitchell
 DeVal, F. C. Garretson
 Dick, L. C. Spencer
 Dickinson, John Canistota
 Dillon, J. A., M.M. Rapid City
 Donahoe, J. W. Sioux Falls
 Donahoe, R. R. Sioux Falls
 Donahoe, S. A. Sioux Falls
 Donahoe, W. E. Sioux Falls

Drissen, E. M. Britton
 Driver, D. R. Sioux Falls
 Drobinsky, M. Estelline
 Duimstra, Fred Sioux Falls
 Dulaney, C. H. Canton
 Eckrich, J. A. Aberdeen
 Eggers, M. W. Sioux Falls
 Eiriburg, I. D. Sioux Falls
 *Elward, L. R. Doland
 Eneboe, E. M. Alcester
 Erickson, E. G. Sioux Falls
 Erickson, J. W. Rapid City
 Eyres, T. E. Vermillion
 Fairbanks, W. H. Vermillion
 Fedt, D. N. Watertown
 Ferthing, Jennings Bryant
 Fiske, R. R. Flandreau
 Fleegeer, R. B. Lead
 Fleishman, M. Cheyenne Agency
 Flynn, E. Pickstown
 Friefeld, S. Brookings
 Fritz, W. H. Mitchell
 *Gage, E. E. Sioux Falls
 Geib, W. A. Rapid City
 Gelber, M. R. Aberdeen
 George, W. A. Selby
 Gillis, F. D. Mitchell
 Gillis, F. D., Jr. Mitchell
 Glood, D. Viborg
 Gorder, W., M.M. Aberdeen
 Graham, H. Chamberlain
 Grauff, L. W. Britton
 Grau, H. J. Rapid City
 Green, C. D. Parker
 Green, R. D. Sioux Falls
 Greenfield, R. E. Sioux Falls
 Greenough, E. E. Sioux Falls
 Gregg, J. B. Sioux Falls
 Gregory, D. A. Milbank
 Groebner, O. A. Sioux Falls
 Grove, A. F. Dell Rapids
 Grove, M. S. Sioux Falls
 Gryte, C. F. Huron
 Gulbrandsen, G. H. Brookings
 Gutch, C. F. Nebraska
 Haas, F. W. Yankton
 Hage, W. J. Sioux Falls
 Hagin, J. C. Miller
 Hamm, J. N. Sturgis
 *Hammond, M. J. Watertown
 Hansen, H. F. Vermillion
 Hare, Helen Jane Rapid City
 Hare, Lyle Spearfish
 Harris, M. A. Sioux Falls
 *Hawkins, A. P. Waubay
 Heib, W. E. Marion
 Heidpreim, G. Deadwood
 Heineman, A. A. Wasta
 Henry, R. B. Brookings
 Hermanson, J. M. Valley Springs
 *Hickman, G. L. Bryant
 Hill, J. F. Yankton
 Hofer, E. A. Huron
 Hofer, E. J. Freeman
 *Hohf, J. A. Yankton
 *Hohf, S. M. Yankton
 Hohm, P. H. Huron
 Hohm, T. A. Huron
 Holland, L. W. Chamberlain
 Holleman, W. W. Rapid City
 Honke, R. W. Wagner
 House, R. M. Sioux Falls
 Howe, F. S. Deadwood
 Huber, R. W. Watertown
 Hubner, R. F. Yankton
 *Hummer, H. R. Sioux Falls
 Hurewitz, M. Colman
 Hyden, Anton Sioux Falls

Ihle, C. W. Sioux Falls
 *Jackson, A. S. Lead
 *Jackson, E. B. Aberdeen
 *Jackson, R. J. Rapid City
 Jacoby, Hans Huron
 *Jacotel, S. A. Milbank
 Janis, J. B. Hoven
 Jernstrom, Roy E. Rapid City
 Jestadt, J. Lemmon
 Johnson, C. A. Belle Fourche
 Johnson, E. A. Milbank
 Johnson, C. F. Yankton
 Jones, W. E. Sturgis
 Jones, W. L. Sioux Falls
 Jordan, G. T. Vermillion
 Judge, W. T. Milbank
 *Kalayjian, D. S. Parker
 Kalda, E. F. Mobridge
 Karlins, W. H. Webster
 Kaufman, I. I. Freeman
 *Keeling, C. M. Springfield
 *Keene, F. F. Wess. Springs
 Keegan, A. Aberdeen
 Kegaries, D. L. Rapid City
 Keller, S. A. Sioux Falls
 Kemper, C. E. Viborg
 Kenney, H. T. Watertown
 Kershner, C. M. Brookings
 Kilgard, R. M. Watertown
 Kilness, A. Sioux Falls
 King, B. F. Aberdeen
 King, L. Sioux Falls
 King, H. I. Aberdeen
 King, Owen Aberdeen
 Kittelson, H. O. Sioux Falls
 Kittelson, J. A. Sioux Falls
 Klima, H. M. Yankton
 Kobza, V. V. Rapid City
 Kohlmeier, F. C. Sioux Falls
 Kooperman, M. Estelline
 Koran, P. H. Rapid City
 Lamb, H. H. Sioux Falls
 Lampert, A. A. Rapid City
 Lanam, M. O. Sioux Falls
 Larsen, M. W. Watertown
 Larson, C. S. Sioux Falls
 Lemley, R. E. Rapid City
 Leigh, F. D. Huron
 Lenz, B. T. Huron
 Leraan, L. G. Sioux Falls
 Lewis, H. R. Mitchell
 Lietzke, E. T. Beresford
 Lindquist, R. H. Canova
 Livingston, R. F. Yankton
 Lloyd, J. H. Mitchell
 Logan, R. A. Aberdeen
 Lovering, J. Webster
 Lowe, C. E. Mobridge
 Lowe, J. A. Mobridge
 Mabee, D. R. Mitchell
 Mabee, O. J. Mitchell
 Magee, W. G. Watertown
 Manning, D. H. Sioux Falls
 Mannion, J. E. Gregory
 Marech, E. R. Sioux Falls
 Martin, H. B. Harrold
 Marturana, F. P. Sioux Falls
 Martyn, W. E. Aberdeen
 Marvin, T. R. Faulkton
 Mattox, N. E. Lead
 Maxwell, R. Clear Lake
 Mayer, R. G. Aberdeen
 McCarthy, P. V. Aberdeen
 McCroskey, R. Rapid City
 McDonald, C. J. Sioux Falls
 McDonnell, J. L. Montrose
 McGreevy, J. V. Sioux Falls
 McGreevy, E. J. Sioux Falls
 McIntyre, P. S. Bradley
 McIntosh, G. F. Eureka

McMullen, R. W. Parker
 McVay, C. B. Yankton
 Melin, J. R. Cheyenne Agency
 Merryman, M. P. Rapid City
 Meyer, W. L. Sanator
 Miller, A. J. Aberdeen
 Miller, G. A. Hot Springs
 *Miller, G. H. Spearfish
 Monk, R. Yankton
 Moran, C. S. Mitchell
 Morgan, R. K. Winner
 Morrissey, M. M. Pierre
 Morse, W. E. Rapid City
 Morsman, C. F. Hot Springs
 Moyer, L. B. Lake Preston
 Muggly, J. A. Madison
 Murdy, C. B. Aberdeen
 Murdy, R. B. C. Aberdeen
 Murdy, R. C. Aberdeen
 Murphy, J. C. Murdo
 Murphy, J. T. Mitchell
 Myrabo, A. K. Sioux Falls
 Namminga, S. A. Fort Meade
 Nelimark, D. R. Mitchell
 Neisius, F. Lead
 Nelson, L. A. Faulkton
 Nelson, J. A. Sioux Falls
 Neves, C. A. Hot Springs
 Newby, H. D. Hot Springs
 Nilsson, F. C. Sioux Falls
 Nolan, B. P. Mobridge
 *Northrup, F. A. Pierre
 Ogborn, R. J. Sioux Falls
 Ohlmacher, J. C. Yankton
 Olson, W. E. Ft. Meade
 Opheim, W. L. Sioux Falls
 Orvedahl, F. W. Hot Springs
 O'Toole, T. F. Rapid City
 *Owen, N. T. Rapid City
 Pangburn, M. W. Miller
 Pankow, L. J. Sioux Falls
 Parke, L. L. Canton
 Patt, W. H. Brookings
 Peabody, P. D., Jr. Webster
 Peeke, A. P. Volga
 Pekelis, E. California
 Pemberton, M. O. Rapid City
 Perry, E. J. Redfield
 Petsch, K. R. Hot Springs
 Pfister, F. F. Webster
 Pittenger, E. A. Aberdeen
 Plowman, E. T. Brookings
 Price, Mary Armour
 Price, Arnold Armour
 Pullman, N. Valley Springs
 Quinn, R. H. Sioux Falls
 Quinn, R. J. Burke
 Radusch, F. J. Rapid City
 Randall, O. S. Watertown
 Ranney, B. Yankton
 Ranney, T. P. Aberdeen
 Rayburn, F. W. Sioux Falls
 Reagan, R. Sioux Falls
 Reagan, P. C. Sioux Falls
 Reding, A. P. Marion
 Reul, T. W. Watertown
 Rich, E. L. Sioux Falls
 Rieb, W. G. Parkston
 Riggs, T. F. Pierre
 Rimsa, A. Onida
 Riner, H. L. Hot Springs
 Robbins, C. E. Pierre
 Rodine, J. C. Aberdeen
 Roper, C. E. Hot Springs
 Rosenberger, H. P. Aberdeen
 Ross, R. R. Lake Preston
 Rousseau, M. C. Watertown
 Rudolph, E. A. Aberdeen
 Rudolph, F. A. Rapid City
 Sackett, R. F. St. Paul

Salladay, I. R. Pierre
 Sanders, M. E. Redfield
 Sattler, T. H. Yankton
 Saxton, A. J. Rapid City
 Saxton, W. H. Huron
 *Saylor, H. L. Huron
 Saylor, H. L., Jr. Huron
 Saylor, Jerome Howard
 Scales, A. B. Pickstown
 Scallin, P. R. Redfield
 *Scheib, A. P. Watertown
 Scheller, D. L. Arlington
 Schmidt, M. A. Watertown
 Schuchardt, I. L. Aberdeen
 Schwartz, E. R. Wakonda
 Sebring, F. U. Martin
 Semones, A. Lead
 Sercl, W. F. Sioux Falls
 Shaw, M. R. Tripp
 Sherrill, S. F. Belle Fourche
 Sherwood, C. E. Madison
 Shreves, H. Sioux Falls
 Simon, S. Pierre
 Skogmo, B. R. Mitchell
 Slaughter, D. Vermillion
 Smiley, J. C. Deadwood
 Smith, A. J. Yankton
 Soe, C. A. Lead
 Spain, M. L. Rapid City
 Spiry, A. W. Mobridge
 Stahmann, F. S. Sioux Falls
 Stansbury, E. M. Vermillion

Steele, J. P. Yankton
 Steele, G. H. Aberdeen
 *Stegeman, S. B. Salem
 Steiner, Peter Lemmon
 Stern, C. A. Sioux Falls
 Stevens, G. A. Sioux Falls
 *Stewart, J. L. Spearfish
 Stewart, N. W. Lead
 Stoltz, C. R. Watertown
 Stransky, J. Watertown
 Studenberg, J. E. Winner
 Suckow, E. E. Garretson
 Sundet, N. J. Kadoka
 Swanson, C. L. Pierre
 Takeyamo, G. Y. Cheyenne Agency
 Tank, M. C. Brookings
 Tauber, K. S. Milbank
 Tesar, C. Pierre
 Thompson, W. Vermillion
 Tobin, F. J. Mitchell
 Tobin, L. W. Mitchell
 Tomlinson, Wray Mitchell
 Torkildson, G. C. McLaughlin
 Totten, F. E. Lemmon
 *Townsend, L. J. Belle Fourche
 Tschetter, Joseph Huron
 Tschetter, J. S. Huron
 Tschetter, P. S. Huron
 Unruh, B. H. Sioux Falls
 Vandemark, G. E. Sioux Falls
 Vandemark, R. E. Sioux Falls

Vandemark, W. E. Sioux Falls
 Van Heuvelen, G. J. Pierre
 Van Lier, P. C. Sioux Falls
 Van Sandt, M. M. Aberdeen
 Vogele, C. L. Aberdeen
 Volin, H. P. Lennox
 Volin, V. V. Sioux Falls
 Vanburg, V. R. Mitchell
 Waldorf, C. E. Redfield
 Walters, S. J. Watertown
 Watson, E. S. Brookings
 *Weishaar, C. H. Aberdeen
 Welbes, M. A. Bridgewater
 Wessman, N. E. Sioux Falls
 Westaby, J. R. Madison
 Westaby, R. S. Martin
 *Whiteside, J. D. Aberdeen
 Whitson, G. E. Madison
 Willcockson, T. H. Yankton
 Willen, Abner Clear Lake
 Williams, D. B. Yankton
 Williams, F. R. Rapid City
 Williams, M. F. Conde
 Wilson, R. W. Burke
 Wold, H. R. Madison
 *Wood, T. J. Huron
 *Wright, O. R. Huron
 Yackley, J. B. Rapid City
 Younker, F. T. Sisseton
 Zeidak, O. Isabel
 Zellhofer, H. W. K. Sioux Falls
 Zimmerman, Goldie E. Sioux Falls

Announcement—

(Continued from Page 215)

report of the 1949 survey on the types of research being conducted on scientific problems relating to lobotomy.

In accordance with the Council recommendation that transactions of the Conference be published for use by Research Study Section members and the large number of investigators in this field, the Proceedings were edited by Dr. Newton Bigelow and published in July 1951 by the National Institute of Mental Health. Copies of the book, (PHS Publication No. 16) may be purchased from Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. for one dollar a copy.

ANNOUNCEMENT!

If you should change your address
 please notify the Journal office—
 300 First National Bank Building,
 Sioux Falls, South Dakota.

WANTED:

Internist who will do some general practice. Well established group clinic in eastern South Dakota city of 14,000. Salary or percentage basis. Partnership in 3 - 4 years.

EDITORIAL PAGE

CRIME PAYS—IN MANY WAYS

In a recent popular magazine there appeared an article on the disintegration of America's moral fiber, having to do with the dishonest acts of normally honest people. The story pointed to evidences of moral breakdown in actions running all the way from government officials accepting bribes to place contracts down to the salesman who puts in for expenses he didn't incur.

Amazingly, its always the other fellow who does this dishonest act. We professional people of high integrity don't have to stoop to petty dishonesty to get along. Or do we?

Recently a patient went to his doctor and was operated for a simple abdominal condition. He was told verbally that the fee was \$150.00. The patient held an insurance policy in a company approved by the medical association and when they received the claim blank the fee was \$250.00. The insurance company paid \$125.00, the limit of its liability, and the patient paid \$125.00. His insurance, which cost him \$90.00 a year, bought him exactly \$25.00 worth of coverage because of the dishonesty of his physician.

Numerous cases — not just this isolated one — have come to light in recent months. The condition is prevalent enough to cause insurance companies to raise their rates. As rates raise, people drop insurance — and soon the clamor is on for government insurance.

Remember — those who may be prone to believe that it doesn't hurt to load the bill when insurance is involved — that your dishonesty is paving the way for a controlled practice of medicine in the future.

Fortunately the percentage of physicians padding insurance bills is low — but those whose crimes are small potatoes, now must reconsider their actions before the ceiling falls.

SELECTION OF COMMON STOCKS

by L. B. Evans, Pres.

DOW THEORY FORECASTS, Inc.

There are only 3 problems connected to stock investing; (1) When to buy, (2) What

stocks to buy, and (3) When to sell.

The first and third points are the all-important ones and generally account for about 80% of one's success or failure in the stock market.

This is true because with few exceptions all stocks go up and down together and if the purchase and sale is timed correctly (in accordance with the major or primary trend of the market) profits are automatic.

Even the most undesirable stocks will go up in a major uptrend and even the very best ones go down in a major downtrend.

Thus, if the purchase is timed correctly, profits will result no matter what stocks are bought and if the sale is not timed correctly, losses will result because even the best stocks go down in a major downtrend.

Nevertheless, in a major uptrend (bull market) certain stocks do go up faster than others and therefore stock selection does offer opportunity for extra profit if executed properly.

Answer in Stock's Action

The answer to proper selection lies in the action of the individual stocks themselves and for best results it is necessary to isolate those issues which rally more than the general market on rallies and decline less than the general market on declines. For this comparison, the Dow-Jones industrial and rail averages are generally used.

If, on a major rally, the Dow-Jones averages advance 20% and a stock you are watching goes up 25% and then on the ensuing decline, the averages go down 10% but your stock goes down only 5% or less, the chances are you have a winner.

Should this relationship continue to exist through another cycle (rally and decline) then you would have no doubt at all that in the following rally your stock would again outstrip the general market.

By the same token, of course, if you are watching a stock that doesn't rally as much as the averages percentagewise on a major rally and then declines more on a major decline, cross it off your list at once for it will only get you into trouble.

Why This Test Works

The reason such a test is not only necessary but invariably works is because factors — both beneficial and detrimental — which are to influence the future of a company cannot always be detected by regular balance sheet analysis in time to buy or sell advantageously.

But these factors will always cast their shadows on the company's stock and reveal themselves in the stock's movements in time to permit action to be taken.

Back in the 1942-46 bull market, this type of action on the part of Gimbel Bros. and Schenley early in the bull market was followed by sensational gains by both. Gimbel rose from 2 to 55 in that market and Schenley from 3 to 80.

In 1948, this same action was characteristic of Richfield Oil and that stock rose from under 20 to nearly 60 by early this year. Late last year, Consolidated Copper — then at 5 — began to show these characteristics and within 6 months it had doubled in price.

This method of selecting possible market leaders may be too troublesome for the average investor but every stock holder should at least be conscious of the importance of watching the comparative performance of his stocks.

Stocks that decline more than others are not "cheap" — they are the most expensive kind because they'll keep on declining.

On the other hand, stocks that rally more than their companions are not necessarily "expansive" but rather may prove to be the soundest with the greatest profit possibilities.

For many years, stocks have been selected by checking the earnings, balance sheet, profit and loss statement, past history of the company, management and apparent future prospects.

That this method is sound and necessary is beyond question. But just as it has been impossible to dependably and consistently judge the direction of the market itself by statistics, so it has been found impossible, in many cases, to judge the future course of individual stocks by such methods when used exclusively.

The method touch on in this article will be found to be very helpful in making up for these deficiencies.



From where I sit by Joe Marsh

Hope "Cappy" Told Him Where To Get Off!

"Cappy" Fisher—who just retired after thirty-five years as a railroad conductor—was talking the other day about a salesman who was often one of his passengers.

"That man was so busy," says Cappy, "he used to bring a dictaphone on the train to catch up on his letters. On one trip he'd been rushing around so much he clean forgot to bring his ticket. Left it on his desk."

When Cappy started to tell him not to worry about the ticket, the salesman busts out with "Who's worried about the ticket? It's just that now I don't know exactly what city I was going to get off at!"

From where I sit, there are people who get so wrapped up in themselves and their ideas they forget "where they're going." Some get so narrow they would tell a man where and how he should practice his profession . . . others would deny their neighbors the right to a glass of beer. Just as trains run on steam and oil, democracies run on freedom!

Joe Marsh

This is



AUGUST
1951
Vol. 4 No. 8

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

NEWS NOTES

NEWS NOTES

Donald Peik, M.D. has joined with **Drs. Breit and Larson** in the practice of radiology and roentgenology at the Sioux Falls Clinic.

Lyman Lowe, M.D. has established a solo practice at Lennox.

Vernon Cutshall, M.D. has recently located in Sioux Falls to practice with **Dr. E. E. Greenough.**

R. G. Mayer, M.D., editor of the Journal and vice-president of the South Dakota State Medical Association, has been named a member of the advisory board to the American Medical Writers Association.

Burton Culp, M.D. has established practice in Volga, associating with **Dr. A. P. Peeke.** **Dr. Culp** is proof of the success of the preceptorship plan of the USD medical school because he was the first under that plan to spend a clinical clerkship in Volga after his sophomore year at the "U."

Robert Borris, M.D. has located at Parker replacing

Dr. Raymon McMullen. **Dr. Borris** is a native of Chicago.

Three Huron physicians have just finished continuation courses at the University of Minnesota. **Drs. H. L. Saylor, Jr.** and **R. A. Buchanan** took the course in surgery while **Dr. H. P. Adams** attended the course in Urology.

The South Dakota Heart Association, incorporated last December has received final affiliation approval from the American Heart Association.

Promotions have been awarded to four members of the staff of the School of Medicine at the University of South Dakota, **Dr. Donald Slaughter,** dean of the School has announced. Two of the men are physicians at Yankton who are members of the clinical teaching staff, and two of them are on the resident teaching staff at the School.

T. H. Sattler, M.D., Yankton, has been promoted from clinical associate professor to the rank of full clinical professor of medicine. **Brooks N. Ranney, M.D.,** Yankton, has been promoted from clinical associate professor to

clinical professor of obstetrics and gynecology.

W. V. Thompson, M.D., who joined the University staff last year as an assistant professor, has been promoted to associate professor and chairman of the department of pathology. **W. O. Read, Ph.D.,** has been promoted from associate in physiology to assistant professor of physiology. He joined the staff in 1949.

USD RECEIVES AMA GRANT

A grant of \$7,500 has been received by the School of Medicine of the University of South Dakota from the National Foundation for Medical Education. **Dr. Donald Slaughter,** dean of the School, in revealing the news of the grant says that plans are not yet complete as to how the money will be used.

William E. Cotter, secretary of the National Foundation for Medical Education, informed **Dean Slaughter** that the money is to be used for medical education in any way seen fit under the direction of the dean of the School of Medicine. The check for the first payment on the grant was received early in July.

PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor



AUGUST MESSAGE

Our 65th Annual Convention of the South Dakota State Pharmaceutical Convention was held in Watertown, South Dakota on June 12, 13, 14. The registration was rated as one of the best. Nature's elements controlling the weather for this event could not have been more delightful as every planned program was enjoyed with the greatest of comfort. Everyone who attended rejoiced and praised the efforts put forth by the host druggists and their wives and employee pharmacists, headed by their very efficient local secretary

Loren Thomas, in the manner that the whole convention was made enjoyable to all. The Allied Travelers, our helpful partners in a convention headed by "Christy" Lederle's Top-notch, provided that so necessary relaxation evening of eats and treats with music that out done all "HADACOL THERAPY."

Our Wholesale Drug Suppliers, The Brown Drug Company of Sioux Falls, again gave us that Russ "Smorgasbord Luncheon." This is not an ordinary meal, or dinner, or luncheon as termed, it is just extra-ordinary, formulated by the President Russ which needs no digestants or antacids afterwards. The Jewett Drug Company of Aberdeen provided the Ladies Breakfast. Harvey is a specialist on menus for the ladies, and no complaints were registered. McKesson & Robbins of Minneapolis, took care of the Ladies Auxiliary Luncheon and Bridge Party and from all reports in the comments made by the ladies, we our characters who enjoy this game also better be prepared for new tactics that may surprise us.

There are also the many manufacturing companies or distributors of products, of which the retail pharmacists are an agent in the final selling to the customer or user, who, contributed liberally with quantity merchandise items as prizes given for attendance awards and otherwise. Their sentiments of cooperation with us are a good-will "play-ball" gesture and our appreciation can be so easily shown by just dropping in the mail a post card or a message that you have received their gift with a few comments of appreciation. Do this at once if you have not already done so. At this convention we had many interesting addresses given affecting many phases of our profession as retail pharmacists. I cannot comment in this first page on all of them. I do want to just briefly say, that Dr. L. J. Pankow, M.D., of Sioux Falls address on "Interprofessional Relations" registered with everyone. He suggested so many moves that we druggists can undertake with just a little application on our part. He also suggested that the "Pharmacy Section of the Journal" be headed by the "Presidents Page." Of course, this challenge was directed to me, and I am going to try not to disappoint Dr. Pankow in his request. This will mean twelve messages, and I hope that you readers will not burn me up with too much criticism. Sticking my neck out, with thoughts and views in print may lead to many controversies, but however varied that your conceptions may be, the purpose and intent of my efforts is to improve our relations with one and another. Doctors and druggists have always worked together as a team and what we need is just a little more team-work as was so ably suggested by Dr. Pankow. In my next message I will touch on these matters. Those of you druggists who did not attend the convention just missed out on a lot of education and fellowship. I am sure that if you would have gone to your doctor about this neglect, he would have prescribed: "ATTEND YOUR CONVENTION EVERY YEAR"

A. O. Bittner, President

NEWS NOTES

Patricia Procknow (State 49) daughter of Mr. and Mrs. Fred A. Procknow, Madison, S. D. was united in marriage to **Gottlieb Dutt**, Seattle, Wash., son of Mrs. Christine Dutt, Gettysburg, S. D. on Sunday, July 15 at Madison, S. D. Miss Procknow has been a pharmacist at St. Lukes Hospital, Aberdeen. Mr. Dutt is also a graduate of S. D. State College and is employed as an engineer in Seattle.

Robert M. Eichman, is now at Walgreens new Self-Service Drug at Sioux Falls, S. D.

Harold K. McMahon formerly at Walgreens, Sioux Falls has been transferred to Minneapolis as a store manager there.

Floyd Wilkening formerly at Walgreens is now at Marshall, Minn. **Ernest Schneider**, formerly at Dunnings, Sioux Falls, is now at Pipestone, Minn.

Ray Sompson who was temporarily laid up with a heart attack is back on the job at Kreislers, Inc., Sioux Falls, since about the middle of July.

Abe Hagger, of Haggars Sioux Valley Drug, Sioux Falls passed away Saturday, July 14th. After graduating from State College Abe worked for several years at the Haggard Drug Sioux Falls, and after serving in the army in World War II opened his own store in 1947.

SIoux FALLS TRIO RANKS HIGHEST IN S. D. PHARMACY TEST

Three Sioux Falls pharmacy graduates rated highest in license examinations given by the state board of pharmacy, secretary of the board **Bliss C. Wilson** said today.

Patrick D. Lynn, **Leslie W. Krumm**, and **Maribel J. Gurtel** all graduates of the State college division of pharmacy, ranked first, second and third respectively in the tests.

Forty-four pharmacists were admitted to practice through the tests given last month. All are State college graduates except one from Creighton at Omaha and one from the University of Nebraska.

FORTY-FOUR PHARMACISTS RECENTLY LICENSED BY EXAMINATION TO PRACTICE IN SOUTH DAKOTA

Pharmacist (College and year graduated)
Mrs. Coletta Lines Auen, (S.D.S.C. 1950)

Place of Employment and City
Denison Drug, Denison, Iowa

Owen G. Benthin, (S.D.S.C.) 1950)

Van De Walle Pharmacy, Sioux Falls
William N. Briley, (S.D.S.C.)

Wheeler Drug Store, Huron
Dan D. Christensen, (S.D.S.C. 1950)

Blue Drug, Spearfish
Milton L. Edlin, (S.D.S.C. 1951)

Sward-Kemp Drug, Jackson, Minn.
Aloysius Ernest, Jr., (S.D.S.C. 1951)

Scallin Drug Co. Inc., Mitchell
Charles E. Fellows, (S.D.S.C. 1951)

Fellows & Clarke Pharmacy, Huron
Elton H. Ferguson, (S.D.S.C. 1950)

U. S. Navy
Morton E. Freeman, (S.D.S.C. 1950)

Hovland Drug, Dawson, Minn.
Maribel J. Gurtel, (S.D.S.C. 1951)

Lynn Drug Company, Sioux Falls
Lonita Joyce Gustad, (S.D.S.C. 1950)

Toller Drug, Sioux City, Iowa
James R. Heiertz, (S.D.S.C. 1950)

Eckland Drug, Mankato, Minn.
Carl C. Johnson, (S.D.S.C. 1950)

Lewis Drug, Sioux Falls
Loren K. Johnson, (S.D.S.C. 1950)

Standard Drug Co., Oberlin, Ohio
Robert C. Kerl, (S.D.S.C. 1951)

Mills Drug, Inc., Rapid City
Leslie W. Krumm, (S.D.S.C. 1951)

Snow Drug Company, Sioux Falls
Jean Marie Levine, (S.D.S.C. 1950)

Beste Drug, Buffalo Center, Iowa
Mrs. JoAnn Starksen Long, (S.D.S.C. 1950)

Quarve Drug, Britton
Patrick D. Lynn, (S.D.S.C. 1951)

Gurtel Drug Co., Sioux Falls
Rodney E. Meyer, (S.D.S.C. 1951)

Hazeldine Drug, Spearfish
Darrell D. Nelson, (S.D.S.C. 1950)

Huhphrey Drug Store, Huron
Carol Faye Opheim, (S.D.S.C. 1951)

Bittner Pharmacy, Aberdeen
Thomas H. Overton, (S.D.S.C. 1950)

Urton Drug, Sturgis
Jack Laxson Perry, (S.D.S.C. 1951)

Standard Drug Co., Cleveland, Ohio
Harry D. Picht, (S.D.S.C. 1951)

H. Kress Drug Co., Mitchell
Richard G. Quarve, (S.D.S.C. 1951)

Quarve Drug, Johnstown, Colorado
Alfred F. Raynes, (S.D.S.C. 1951)

Jones Drug Store, Custer

(To be Continued Next Month)

AUXILIARY ACTIVITIES

Minutes of the 41st Annual Meeting of the Woman's Auxiliary to the South Dakota State Medical Association 1951

The first general session of the 41st annual meeting of the Woman's Auxiliary to the South Dakota State Medical Association was opened on June 4th at 10.00 a. m. in the Ballroom of the Alonzo Ward Hotel in Aberdeen, with Mrs. A. P. Reding, Marion, State President, presiding.

Minutes of the Executive Board Meeting held November 29th in Sioux Falls at the home of Mrs. V. V. Volin, were read and approved.

The Auxiliary Pledge, lead by Mrs. Reding, was repeated in unison by the assembled members. Minutes of the last Auxiliary session of the 1950 meeting held in Huron, May 23rd, were read and approved.

Mrs. Harold E. Wahlquist of Minneapolis, the President-elect of the National Auxiliary, was introduced as our convention guest.

Mrs. A. P. Reding, State President, submitted the following report of the year's activities:

PRESIDENT'S REPORT—1950-1951

"Mrs. Wahlquist, Past President, Officers, Committee Chairmen and Auxiliary Members. As we finish another auxiliary year, it is again time to stop and take inventory to see where we stand. We can not report any spectacular activities, perhaps, but I definitely feel that we have laid a solid foundation on which to continue to slowly build an active, progressive auxiliary.

This is my report:

National Meetings: I attended the Auxiliary Sessions of the A. M. A. in San Francisco last June as Presidential Delegate. Your President-elect, Mrs. Wold, and I attended the Chicago Conference for State Presidents and Presidents-elect, together with the National Officers, in Chicago in November. I found these sessions a thrilling experience and a source of much inspiration and useful information. Reports of these meetings appeared in the September and December issues of the S. D. Medical Journal.

Executive Board Meeting: Our first Executive Board Meeting was held in Sioux Falls November 29th at the home of our Corresponding Secretary-Treasurer, Mrs. V. V. Volin. At this time we made definite plans to publish a NEWSLETTER as soon as possible. The Auxiliary was to pay all expense (paper, envelopes and postage) and the mimeographing and mailing was to be done at the State Medical Association Office.

NEWSLETTER: Two issues of "The Auxiliary News" were published since the first of the year, the first the early part of February and the second, the Pre-Convention number, the middle of May. The purpose is to keep in contact with all doctor's wives in the state. In this way all suggestions, National advise and outlines, notices and general auxiliary news can be given to all members. This seemed imperative since some Districts have but few meetings during a year. It is the plan to publish the AUXILIARY NEWS quarterly next year.

I recommend that a NEWSLETTER Committee be appointed to be in charge for next year. This is too much responsibility for the President to assume. It must be more representative.

AUXILIARY ACTIVITIES: The Auxiliary section of the monthly South Dakota Journal of Med-

icine and Pharmacy is known as AUXILIARY ACTIVITIES. I furnished copy for this publication each month, and attempted to get District News, reports of National Meetings etc. out to the members. However, I find that this Journal goes to the Doctor's Office and most auxiliary members never see our efforts!

Visits to Districts: One of the most pleasant duties of the State President is visiting the various Districts . . . I only wish that I could have gone to all of them. I did visit 5, Sioux Falls, Mitchell, Yankton, Huron and Aberdeen. Sorry I couldn't accept my invitation from the Pierre District. One official visit of a state officer to a District can do more than most all other correspondence during the entire year. When I spoke to the Districts I explained some of the current changes in Auxiliary Procedure, urged them to have discussion periods at some of their meetings, to promote Today's Health, sponsor Health Day Programs etc. Several of the Districts did sponsor Health Day Programs for the public and a number of such programs are already being planned for this fall.

Aberdeen, District 1, has reorganized this year and will be ready to do it's part in the state organization next year.

DISTRICT ACTIVITIES: Much of our work in South Dakota is done more or less as individuals rather than as a group. Many members participate in community projects such as Cancer Control, March of Dimes, Christmas Seals to TB, Red Cross Home Nursing and First Aid Courses, Civil Defense, as well as support their hospital auxiliaries, Crippled Children's Hospital and the Benevolent Fund for Student Aid.

TODAY'S HEALTH: We have increased our subscription to 75 from 25 last year. I believe that we should stress the sale of this important health magazine more in the future. This is one of the easiest mediums of Public Relations and yet one of the best, especially in our state where we do not have a staff of Trained Speakers to champion our cause. This authentic health magazine is worthy of our support and it is the one specific project, which the AMA asked the Auxiliary to do for them.

BULLETIN: I firmly believe that all State and District Officers should have the Bulletin. It is known as the text book of Auxiliary. This official publication of the National Auxiliary, published quarterly, contains National reports, outlines, suggestions etc. Well informed officers make more competent leaders.

Iowa Meeting: Your president was invited to be a guest at a luncheon in honor of Mrs. Theodore Heinz, National Public Relations Chairman, at the Iowa State Meeting in April, which was held in Sioux City. Iowa has had some alert officers the last few years and is really active in a number of Auxiliary projects.

Conclusion: May I express my gratitude to all Officers and Committee Chairmen and to the District Officers for their sincere cooperation. I want to especially thank the staff at the State Medical Association Office for the assistance in getting the NEWSLETTERS out to you. It has been a privilege and an honor to serve as your president this year. I pledge continued loyalty to the new officers and to the Woman's Auxiliary to the South Dakota State Medical Association."

Mrs. Reding announced the following as members of the Nominating Committee for 1951:

Mrs. Merle Pangburn, Miller, Chr.
 Mrs. Wm. Fritz, Mitchell
 Mrs. Wayne Geib, Rapid City

Mrs. C. J. McDonald, Sioux Falls, acting as Corresponding Secretary and Treasurer in the absence of Mrs. V. V. Volin, gave the financial report and Bulletin report, both of which were approved and accepted.

Mrs. Reding called attention to the material on the display tables on the mezzanine and suggested members visit this exhibit and make use of whatever material might be appropriate in local areas. The exhibit included sample Newsletters from other states, sample copies of TODAY'S HEALTH, and various material and pamphlets sent out by the Health Education Service.

A discussion of state finances was held and an explanation of the cost of the NEWSLETTER was made. Since this was an added strain on our meager budget, Mrs. Reding and Mrs. Wold announced that they were willing to forgo their expense allowance of \$50.00 each for the Chicago Conference, which was passed at last year's convention.

Mrs. L. C. Askwig, Pierre, made a motion that the Public Relation Chairman of each district be in charge of getting material for Auxiliary Activities, published in the Journal, to the State President early each month. The motion was seconded and carried.

The report of Today's Health Chairman, Mrs. Merritt Auld, Yankton was read in her absence by Mrs. Reding. The report showed an increase in subscriptions from 25 last year to 75 this year. We were urged to sell more subscriptions as one of our Auxiliary projects next year.

A discussion concerning a state pin was led by Mrs. Russell Brown, past president from Watertown. Mrs. Brown explained the Nebraska plan of presenting a pin to the in-coming president to be worn during her term of office and given to her successor at the next convention. The Nebraska Medical Association presents each past president with a jeweled pin as she concludes her term. A discussion of the advise ability of adopting a similar plan followed and it was decided that no action be taken at this time. However, any accredited member may purchase a pin to wear. Several members have pins at this time.

Promptly at 11:00 a.m., Mrs. John C. Hagin, Miller, presented a beautiful Memorial Service in honor of the Auxiliary Members who passed away during the past year:

Mrs. D. J. Alway, Aberdeen
 Mrs. C. E. McCauley, Aberdeen
 (Charter member)
 Mrs. F. L. Class, Huron
 Mrs. F. M. Blezek, Tabor
 Mrs. Mabel Thomas, Huron
 Mrs. J. C. Shirley, Huron
 Mrs. R. Reagan, Sioux Falls

The following convention committees were appointed:

Courtesy: Mrs. A. B. Scales, Pickstown
 Mrs. L. C. Askwig, Pierre

Auditing: Mrs. Lyndon King, Sioux Falls
 Mrs. Harry Grau, Rapid City

Recommendations: Mrs. Paul Reagan, Sioux Falls
 Mrs. F. C. Nilssen, Sioux Falls

Meeting adjourned.

Mrs. E. R. Schwartz
 Recording Secretary

The second session of the Woman's Auxiliary to the South Dakota State Medical Association was held in Parlor A in the Alonzo Ward Hotel, June 5th at 9:30 a.m. Meeting opened with the Auxiliary Pledge. The minutes of the first session were read and approved.

A radio was brought to the convention room in order that the members might listen to an inter-

view of Mrs. Howard Wold on the radio program, "Listen, Ladies" over KSDN, Aberdeen. Mrs. Wold ably discussed objectives and activities of the Woman's Auxiliary, both nationally and on a state level.

An introductory School of Instruction on auxiliary work, was held, for district officers, for the first time. Mrs. Reding opened the discussion by briefly enumerating the duties of the elective officers and stressed the need of unity of purpose. Mrs. Wold did likewise for the appointive officers. Mrs. Harold F. Wahlquist, National President-elect from Minneapolis, our convention guest, added suggestions to those already mentioned.

The morning session ended with an address by Dr. L. J. Pankow, President of the South Dakota State Medical Association. Dr. Pankow expressed his views on the purpose of the Woman's Auxiliary . . . and thought perhaps their greatest duty was in their homes and that their purpose should be to keep this home and their doctor husband a happy one. A doctor, free of home burdens, can practice better medicine.

There being no further business, meeting adjourned.

Mrs. E. R. Schwartz
 Recording Secretary

The afternoon session was called to order by the president, Mrs. A. P. Reding, in parlor A of the Alonzo Ward Hotel, June 5th at 2:00. Minutes of the morning session were read and approved. The following reports by Standing Committee Chairman were read:

Organization: Mrs. Howard Wold

Historian: Mrs. Wm. Sercl . . . read by Secretary

Legislative: Mrs. I. R. Salladay . . . read by Mrs. Askwig

Benevolent Fund: Mrs. E. R. Schwartz, Chr.

District Reports

Dist. 1. Mrs. A. J. Miller
 Dist. 2. Mrs. C. Rodney Stoltz
 Dist. 3. Mrs. D. S. Baughman
 Dist. 4. Mrs. L. C. Askwig
 Dist. 5. Mrs. Floyd D. Gillis, Jr.
 Dist. 7. Mrs. C. J. McDonald
 Dist. 8. Mrs. E. R. Schwartz

No reports from the other districts.

A letter which was just received from a past president, Mrs. N. K. Hopkins, Ellensburg, Wash. was read. She expressed her regrets that she could not attend the Anniversary Luncheon, June 4th and asked to have some newspaper clipping sent to her if possible.

A motion was made by Mrs. King that Mrs. A. P. Reding be named editor of the NEWSLETTER for the coming year. Motion seconded and carried.

Mrs. Merle Pangburn, chairman of the Nominating Committee, presented the following slate of officers for 1951-52.

President: Mrs. Howard Wold, Madison
 President-elect: Mrs. V. V. Volin, Sioux Falls
 First Vice-Pres.: Mrs. A. B. Scales, Pickstown
 Second Vice-Pres.: Mrs. L. C. Askwig, Pierre
 Secretary-Treas.: Mrs. E. R. Schwartz, Wankonda
 Recording Secretary: Mrs. I. R. Salladay, Pierre
 Historian: Mrs. A. P. Reding, Marion
 (Immediate past pres.)

Motion was made by Mrs. C. J. McDonald and seconded by Mrs. Baughman that the secretary cast a unanimous ballot in favor of the slate as presented. Motion carried.

Mrs. Wold, newly elected president spoke briefly and announced the following chairmen of state Committees:

Bulletin: Mrs. Joe Tschetter, Huron
 Public Relations: Mrs. Walter Patt, Brookings
 Today's Health: Mrs. Wayne Geib, Rapid City
 Legislation: Mrs. C. Rodney Stoltz
 Organization: Mrs. A. B. Scales, Pickstown

Program: Mrs. V. V. Volin, Sioux Falls
Meeting Adjourned.

Mrs. E. R. Schwartz
Recording Secretary

The minal meeting was held at 10 o'clock Wednesday morning June 6th on the mezzanine of the Alonzo Ward Hotel. Minutes of the previous meeting were read and approved as read.

Mrs. E. R. Schwartz was reappointed as Benevolent Fund Committee Chairman.

Mrs. A. B. Scales, Pickstown, read the following report of the Courtesy Committee:

We, your Courtesy Committee, recommend that a card of appreciation be sent by our Recording Secretary to the following:

- (1) Woman's Auxiliary of District 1 and to Mrs. Gelber, Convention Chairman.
- (2) Mrs. Marold F. Wahlquist, President-elect of the National Auxiliary.
- (3) Mrs. A. P. Reding, Retiring President
- (4) Mrs. I. R. Salladay, State Legislative Chairman

Mrs. L. N. Grosvenor, Huron, a Past President, congratulated the younger members on their worthwhile and enjoyable Auxiliary Meetings.

Mrs. C. J. McDonald read the report of the Auditing Committee and the report was approved.

Mrs. Wold commended Mrs. Reding on her excellent work as State President.

Mrs. D. S. Baughman recommended that a door prize drawing take place at each session for the women who arrive at the Auxiliary Meetings by the time named on the program. Consideration of some such scheme is being considered for our next convention.

A motion was made and seconded that all outstanding bills be paid, and that the President be allowed her \$100.00 discretionary fund and the President-elect her \$50.00 expense account.

At the suggestion of Mrs. Wahlquist, that a Chairman for the next Convention should be named this year, this action was taken. A motion was made and carried that Mrs. C. J. McDonald of Sioux Falls be General Convention Chairman of the 1952 Auxiliary Meeting in Sioux Falls. Meeting Adjourned.

Mrs. E. R. Schwartz
Recording Secretary

PRESIDENT'S MESSAGE

Just a year ago I was trying to write my first message to be published in the Journal . . . Today I am writing my last as your State President. I wish to take this opportunity to express my sincere appreciation to all of those who help make this year a success.

I am so grateful for the wonderful cooperation I received from the Aberdeen District, and thank them sincerely for the wonderful convention. They made our 40th Anniversary Celebration one to be long remembered. I will give some of the details of these lovely social functions in the first NEWS-LETTER this fall for the benefit of those who were unable to attend the convention.

The friendships and acquaintances that I made through my contacts with the various Auxiliary members during the past year, shall be treasured. I shall be looking forward to hearing from some of you in connection with the publishing of the NEWSLETTER this year.

It has been a real pleasure and a privilege to work with the Woman's Auxiliary to the South Dakota Medical Association.

Mrs. A. P. Reding

OFFICERS FOR 1951-52

President: Mrs. Howard Wold, Madison
President-elect: Mrs. V. V. Volin, Sioux Falls
First Vice-President: Mrs. A. B. Scales, Pickstown
Second Vice-President: Mrs. L. C. Askwig, Pierre
Corr. Sec.-Treas.: Mrs. E. R. Schwartz, Wakonda
Recording Secretary: Mrs. I. R. Salladay, Pierre
Historian: Mrs. A. P. Reding, Marion

BENEVOLENT COMMITTEE

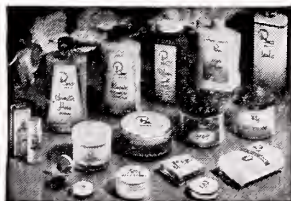
Mrs. E. R. Schwartz, Chr., Wakonda
Mrs. A. P. Reding, Marion
Mrs. Howard Wold, Madison
Mrs. W. H. Fritz, Mitchell

DELEGATES TO A. M. A. CONVENTION Atlantic City

Mrs. Howard Shreves, Sioux Falls
Mrs. Russell Brown, Watertown

- (1) Used Picker vertical flouroscope with (new) x-ray tube, foot switch, Engeln transformer, 30Ma, 90KV with pedestal control. \$425.00 Purchaser to pay freight.
- (2) Hanovia — Luxor — Alpine Lamp. Brand new. Cost \$335.00. Will sell for \$275.00.

Tri-State Clinic, Belle Fourche, S. D.



UNSCENTED COSMETICS FOR THE ALLERGIC PATIENT

AR-EX Cosmetics are the only complete line of unscented cosmetics regularly stocked by pharmacies. To be certain that your perfume sensitive patients do not get scented cosmetics, prescribe AR-EX Unscented Cosmetics. SEND FOR FREE FORMULARY.



FREE FORMULARY

DR. _____
ADDRESS _____
CITY _____
STATE _____

AR-EX COSMETICS, INC.,

1036 W. VAN BUREN ST.,

CHICAGO 7, ILL.

The Acute Abdomen*

PHILIP THOREK, M.D.
CHICAGO, ILLINOIS

The subject of the acute abdomen will always present an interesting challenge to the practitioner and surgeon alike. I have examined charts from the surgical services at the Cook County Hospital for a period of fourteen years, the purpose being to determine which diseases are most frequently mistaken in the acute abdomen. To my surprise I did not find fifty or seventy-five conditions which confuse us, but rather six outstanding ones that we mistake most frequently. These six conditions are:

1. Acute Appendicitis
2. Acute Cholecystitis
3. Perforated Peptic Ulcer
4. Acute Hemorrhagic Pancreatitis
5. Renal Colics
6. Coronary Disease

There is a seventh disease which deserves special consideration, namely, salpingitis. Acute or chronic salpingeal pathology is frequently associated with a perihepatitis which produces pain in the right upper quadrant (pseudo-gallbladder pain). Because of this, gallbladder explorations and other surgical procedures have been done in cases of salpingitis, resulting in danger to the patient and embarrassment to the surgeon.

To make a diagnosis one must have a simple and workable plan in mind. Our plan consists of four headings, namely, history, present symptom complex, physical examination and laboratory data. This routine has served us well and we utilize it daily.

ACUTE APPENDICITIS

The more one sees of acute appendicitis, the more one respects the condition. The statement "only an appendix" is indeed a dangerous one. This condition is most frequently found in individuals under the age of forty and is somewhat more common in

males. It will be recalled that gallbladder conditions appear most frequently after the age of forty. The story the patient relates is usually quite stereotyped. To put it in his language: "Something I ate gave me a belly-ache." This is his way of describing acute epigastric distress. When he gets his "belly-ache" he often attempts to obtain relief with either a cathartic or an enema. Within the first twenty-four hours his "belly-ache" becomes a soreness low on the right side. His acute epigastric distress has become localized to the right lower quadrant. The "two-question test" is both useful and time-saving. Question Number 1: "Where was your pain when it started?"; to this interrogation the patient points to his entire abdomen. Question Number 2: "Where does it hurt you now?"; he then points to the right lower quadrant, usually McBurney's point. This simple method of having the patient demonstrate diffuse pain which localizes to the right lower quadrant will diagnose the vast majority of cases of acute appendicitis.

Nausea and vomiting have been impressed upon us as being associated with appendicitis. This is the exception and not the rule. Anorexia, or loss of appetite, is more constant and more important than either nausea or vomiting. Anorexia, nausea, and vomiting are three degrees of one symptom; anorexia is the mildest form and is associated with mild distention of the appendix; nausea the middle degree, is due to moderate distention; and vomiting, the maximum degree, is found in greatly distended appendices. The most common symptom in acute appendicitis is anorexia, and if the patient states that his appetite is not altered we doubt the diagnosis of an acute appendix. Two complaints which are extremely rare in acute appendicitis are diarrhea and chills. These are probably found in less than one per cent of the cases. Constipation is the rule.

Fever is not an early finding in acute appendicitis; in fact, if present it is suggestive

*Presented at the Seventieth Annual Meeting of the South Dakota State Medical Association, Aberdeen, South Dakota, June 4, 1951.

From the Departments of Surgery, University of Illinois, Cook County Graduate School of Medicine, Cook County Hospital, American Hospital and Alexian Brothers' Hospital.

of peritoneal soiling. It is true that cases of acute appendicitis may have a fever of 102°, or 103°, but these are no longer cases of appendicitis; they are cases of far advanced peritonitis. Children prove the exception to this rule. If appendices could be operated upon when the temperature is below 99° the mortality would be very low.

Acute appendicitis does **not** give right rectus rigidity. Although the reverse is taught in many schools and text books, this point should be clarified. It is impossible for an individual to contract his right rectus muscle without contracting the left; therefore, when pressure is made upon an inflamed area, both rectus muscles contract. When only one rectus is rigid it suggests an underlying mass, such as a tumor or abscess. When both recti contract to pressure it should be considered "muscular defense" rather than right or left rectus rigidity. The importance of this bears emphasis when we realize that diagnosis, treatment and prognosis may depend upon the presence of right rectus rigidity or simple muscular defense.

The iliopsoas and obturator signs are not signs which diagnose acute appendicitis, but rather locate an acute appendix. Probably a misconception has arisen because these signs are usually discussed under the heading of acute appendicitis; they may, however, be produced in other diseases. The right iliopsoas sign is elicited by placing the patient on his left side and hyper-extending the right leg. If positive, pain is produced over the iliopsoas fascia which will be manifested in the region of the right lower quadrant. In the presence of a history of acute appendicitis this would signify that the inflamed appendix is overlying the iliopsoas and is retrocecal. A positive obturator sign will locate an inflamed pelvic appendix. It is conducted in the following way: with the patient on his back the thigh is flexed upon the abdomen and the leg upon the thigh; the leg is then abducted. This causes internal rotation of the thigh and stretches the obturator internus muscle. If this produces pain it is diagnostic of a fasciitis involving the obturator fascia, which could be caused by an inflamed tube, appendix, ovarian cyst, etc. If the patient elicits a history of acute appendicitis with a positive obturator sign, we conclude that the appendix is low-lying and in the pelvis. Rovsing's sign

is also helpful. It is elicited by pressing over the cecum, the colonic gas which has been pushed to the right will produce pain over the cecal region; this is quite diagnostic of acute appendicitis.

Routine bi-digital examinations are done; at times an acute appendix or appendiceal mass may be felt. Late and neglected appendices may produce a pelvic abscess which points rectally or vaginally, and this examination reveals the proper site and time for incision and drainage.

The laboratory data usually consist of a white blood count and a urinalysis. More important than the white blood count or urinalysis is a differential blood count; this is easy to do and is more accurate. If the "poly" count is high, it is assumed that an acute infectious process is present; a high "poly" count in the presence of a low white count means a poor prognosis. The urinalysis is usually negative but may be misleading; a few red cells in the urine are not pathognomonic of renal pathology. Negative urines have been recorded where a renal stone completely blocks the ureter so that no blood or pus can pass into the bladder.

The reason for the high mortality in acute appendicitis can be summarized in the alliteration utilizing the three "P's", namely, Purgation, Procrastination and Poor Surgical Judgment.

ACUTE CHOLECYSTITIS

The dictum that certain types of people are predisposed to certain types of diseases seems to be correct. The gallbladder type is described as fair, fat and forty, usually being a female in the latter third or fourth decade and somewhat obese. There is always an exception to the rule, hence, the most fulminating hydrops of the gallbladder on our service was seen in a young, thin boy of sixteen. The age of forty is related to a previous history of pregnancy, and this is theoretically explained in the following way: the average female has her children in the second decade of life and while pregnant she develops a physiologic hypercholesterolemia. Some of this cholesterol deposits on the mucous membrane of the gallbladder, forms polypi which break off and become the nuclei for stones. It may take from ten to twenty years for gallstones to attain any appreciable size, so that by the time she reaches her fourth de-

cade the stone is large enough to obstruct or irritate. Nulliparous women can also have gallstones or gallbladder disease, but this too, is the exception and not the rule.

The history of recurrent attacks of abdominal pain in a middle aged female, so severe that the physician must administer a sedative, is an acute gallbladder until proved otherwise. Acute appendicitis does not require morphine; renal colics will be differentiated presently, and coronary occlusion is rare in the female. One of the most unusual lesions noted in the female is a perforated peptic ulcer. The gallbladder patient also presents a previous history of "selective dyspepsia." By this we mean that there are certain specific foods that she cannot tolerate. There are four primary offenders to these foods: they are fried and fatty foods, raw apples, cucumbers and cabbage. The patient does not use the term "dyspepsia," but describes this distress as the two "B's": namely, bloating and belching. To summarize and describe the gallbladder patient one may use an alliteration and state that she is the patient with the seven "f's": she is the Fair, Fat, Fertile, Flatulent, Flabby, Female of Forty.

The complaint is one of pain, and it is important to determine the type of pain which is present. A constant pain is due to edema, but colicky pain is caused by obstruction. This is one of the factors which indicate whether the case should be treated conservatively or surgically. It is unwise to treat an obstructed lesion conservatively since these are cases which result in early gangrene and perforation. Morphine should not be used in gallbladder disease because it is a smooth muscle contractor, and since the gallbladder is a smooth muscle organ one should not administer a medicament which would stimulate its activity. By increasing muscle tonus, morphine may actually aggravate or provoke gallbladder pain and colic. One should not state, however, that the drug must never be used in gallbladder disease since it still has its place, namely, to prevent shock. These patients are treated first with nitrite therapy. One breaks an amyl nitrite bead and lets the patient inhale the vapors; 1/100 grain of nitroglycerin is placed under the tongue, and 3 grains of sodium amytal or any other barbiturate is given by mouth. If this gives no relief we administer a hypodermic which

consists of 100 mg. of demerol and 1/100th of a grain of nitroglycerin. Should these measures fail, antispasmodic therapy with such drugs as papaverine, aminophylline, et cetera, is tried. Morphine is used only after all other measures have failed.

Gallbladder pain is usually located under the right costal margin, but may be referred to the stomach since these two organs originate from the same embryologic segment. The stomach responds to this stimulus in one of these types of gastric spasms: (1) pylorospasm, (2) midgastric spasm and (3) cardiospasm. If a pylorospasm is produced the gallbladder condition might be confused with peptic ulcer; if midgastric spasm results, a stomach carcinoma may be erroneously diagnosed; and if associated with cardiospasm, the pain appears on the left (pseudo-coronary pain) and coronary disease may incorrectly project itself into the diagnostic picture.

Referred pain should not be confused with radiation of pain. By radiation we mean that gallbladder pain, located under the right costal margin, may radiate along the path of the seventh intercostal nerve to the inferior angle of the right scapula, or the interscapular region. Gallbladder pain, therefore, cannot radiate to the right shoulder. Shoulder pain is an entirely different mechanism which involves the phrenic nerve and is indicative of peritonitis. When a gallbladder patient has true shoulder pain a diagnosis of gangrenous or ruptured gallbladder with biliary peritonitis should be made.

Temperature, pulse and respirations are included under the heading of physical examination. The patient with an acute gallbladder has an early high fever, hence, a temperature of 102° is not unusual within the first twelve to twenty-four hours of acute cholecystitis. The early fever is explained by the absence of a submucosa. Since this tough resisting layer is lacking, there is greater chance for early contamination and absorption in the peritoneal cavity. The patient has a pulse which is increased according to the temperature, therefore, for every degree rise in fever there will be approximately a ten beat increase in pulse rate. Respirations are slightly increased because breathing is painful. This is due to the fact that the inflamed gallbladder rubs against the sensitive parietal peritoneum; because of

this, acute gallbladder disease may be confused with pneumonia or pleurisy.

Although pain, a symptom, may be referred anywhere along its nervous path, tenderness, a physical finding, remains at the site of pathology. This is an excellent diagnostic rule having few if any exceptions. The tenderness of gallbladder disease will be located in the region of the right costal margin. If it is most marked on a level with the umbilicus, it may be difficult to determine whether the condition is an inflamed, low-lying gallbladder or an acute high-lying retrocecal appendix. Two ways aid in the differentiation of these two conditions. First, we recall that the normal abdomen reveals a tympanitic note to percussion in all four quadrants. If the tenderness opposite the umbilicus is due to an inflamed gallbladder, we assume that the organ is unusually large or that a ptotic liver with an inflamed gallbladder at its free border is present. This would cause an obliteration of the normal tympany in the right upper quadrant and in its place the percussion note would be one of fullness or flatness. If the patient presents tenderness on the level with the umbilicus and retains normal tympany in the right upper quadrant, this would point to a high-lying retrocecal appendix. Another method of differentiating the gallbladder and appendix is by means of Ligat's test. This test locates areas of hyperesthesia over an inflamed organ. If the tenderness is due to gallbladder disease, an area of hyperesthesia (elicited by picking up the skin and letting it drop) is present from the umbilicus upward to the right costal margin. If the tenderness is due to an acute appendix, the area of hyperesthesia will be found from the umbilicus down to Poupart's ligament.

A rectal examination is done as a routine in every physical examination. More important than the rectal or vaginal examination is a so-called bi-digital, which is conducted by placing the index finger in the vagina and the middle finger in the rectum with the perineum in between. This will immediately orient the examiner and adnexal pathology will be revealed.

A flat x-ray film should be taken in every acute abdominal condition. One may determine whether a calcified gallbladder or visible stones are present. It also gives an indication as to whether or not the liver is

enlarged or ptotic. Routine laboratory tests are done.

PERFORATED PEPTIC ULCER

This condition is rare in females. Usually a previous history of peptic ulcer or hemorrhage can be obtained, but the onset may be with perforation.

The patient states that he was seized with a sudden pain, usually after eating; this was so severe that it doubled him up. The classical picture of perforated peptic ulcer with board-like rigidity and a shock-like syndrome is too well known to bear repetition. Two signs which should be sought for in every case, however, are: (1) the findings with auscultation and (2) the presence of a pneumoperitoneum. Auscultation reveals an absolutely silent abdomen when an ulcer perforates, leaks and soils the peritoneal cavity. This is not new, since the late J. B. Murphy stressed the importance of this finding many decades ago. When intestinal sounds are present, the diagnosis of perforated peptic ulcer is remote. There are exceptions, and one of these will be discussed presently under the subject of forme fruste ulcer. The next sign which helps clinch the diagnosis is the demonstration of a spontaneous pneumoperitoneum. Normally a magenblase or stomach air bubble is present. When an ulcer perforates, this air bubble escapes into the general peritoneal cavity, and can be demonstrated either by percussion or with the fluoroscope; the latter is by far the more accurate. The patient is placed on his left side so that the free air bubble may gravitate upward between the liver and the right hemidiaphragm. By so doing, the liver is displaced downward and is separated from the diaphragm. Normally, the liver hugs the diaphragm and no air space is visible between them. If this air is of an appreciable amount, normal liver dullness is obliterated and in its place a tympanitic note is produced by percussion. The sign is easy to demonstrate, quite pathognomonic perforated peptic ulcer, and present in about seventy per cent of all cases.

The forme fruste ulcer deserves special mention. The term refers to a pin-point perforation in the stomach or duodenum which is immediately sealed over by muscular contraction or by the overlying liver. Therefore, the spillage is minimal and the amount of peritoneal soiling is small. Such patients may

experience a sudden sharp pain in the epigastrium, but the typical physical findings are lacking. This patient may be able to straighten up and walk about. Abdominal sounds are usually present and the air bubble may remain intragastric, having had no chance to leave the small perforation. These patients, therefore, present a misleading picture and have been misdiagnosed. However, with the ingestion of their next meal they usually re-perforate and then present the typical findings.

The temperature, pulse and respirations will depend upon whether or not shock is present. Most perforated peptic ulcers present a shock-like picture which varies in its intensity. The shock associated with perforated ulcer responds rapidly to therapy. Within a few hours, the classical picture of peritonitis develops with the associated increase in temperature, pulse and respiratory rate.

The contents from a perforated ulcer may pass downward along the so-called "paracolic gutter of Moynihan," pool around the appendix and produce exquisite tenderness at McBurney's point. The diagnostician must then be on his guard, since such a history would suggest an epigastric distress with localization to the right lower quadrant which could be confused with an acute appendix. Upon exploratory operation, free fluid will be found in the peritoneal cavity with all signs of a peritonitis, and a red and injected appendix seen and removed. These patients usually die if the leaking ulcer is overlooked. This catastrophe can be avoided if, before closing the abdomen, the appendix is opened and the mucous membrane examined. Since acute appendicitis starts in the lumen of the appendix and travels outward, a normal appearing mucous membrane would suggest looking elsewhere for the cause of the peritonitis.

Laboratory data include the flat x-ray film which has been discussed under the subject of spontaneous pneumoperitoneum. Routine blood count and urinalysis are done. Some of these patients might have bled, and although perforated ulcers are known not to produce massive hemorrhage, signs of a secondary anemia may be present.

ACUTE HEMORRHAGIC PANCREATITIS

It is important to recall that this disease

may appear in one of two forms: either acute edematous pancreatitis or hemorrhagic pancreatitis. The former presents a mild clinical picture, but the latter which is associated with fat necrosis and occasionally a hemorrhagic peritonitis produces a fulminating one. The acute edematous form usually improves rapidly without therapy within 48 hours, but hemorrhagic pancreatitis gets progressively worse and often requires surgical intervention. It is the hemorrhagic type, therefore, which is important to identify and treat promptly.

Although the etiology of pancreatitis is unknown, there seems to be a mechanical factor which is associated with Spasm, Stones, Swelling and Stasis. Recent work seems to emphasize the relationship between acute pancreatitis and acute cholecystitis. This seems to be due to a common factor which is an obstruction distal to the junction of the pancreatic and common bile ducts converting them into a "common channel." An actual reflux of pancreatic juice into the gallbladder during an attack of acute pancreatitis has been shown. The patient who develops acute pancreatitis is usually of the same type that develops gallbladder disease, therefore, the condition is more common in females, rarely occurring before the age of forty, and is seen in stout people. The ratio of colored to white is 1 to 50. The attack usually follows the ingestion of a heavy meal. The pain is dramatic, sudden and excruciating; it is felt in the epigastrium, and radiates into one or both loins. In this way pancreatic pain radiation resembles an inverted fan. When the patient sits up or lies on his abdomen, the pain is relieved, and is aggravated when he is on his back. Hence, in most pancreatic conditions, be they tumors or inflammations, the patient is usually found lying on his abdomen or in a sitting position. Reflex vomiting or retching almost always occur; emesis which is truly reflex in nature is never feculent.

Physical examination reveals a patient who is usually in shock with cold and clammy extremities, subnormal temperature, and a rapid, thready pulse. Local epigastric tenderness is almost present and is associated with a type of muscular defense which is localized to the same area. The rigidity is not truly board-like in nature, and the tenderness is most marked midway between the umbilicus

and the xiphoid. An occasional finding is ecchymosis in one or both loins, or at times around the umbilicus. This is due to extravasated blood which finds its way around the retroperitoneal space and presents itself as greenish yellow or purplish discolorations. This finding, however, takes two or three days to appear. Mild jaundice is present in about half of the cases; this is explained by the fact that the common duct is pressed upon by a swollen head of the pancreas. Abdominal auscultation usually reveals a quiet but not silent abdomen.

Laboratory findings may be helpful in the diagnosis. An increase of serum amylase is specific in the acute phase, although a normal reading does not rule out acute pancreatitis. Polowe has emphasized the importance of determining the blood amylase activity in terms of cuprous oxide precipitation. He has shown that moderate to marked blood amylase activity is almost always associated with disease of the pancreas, and normal or decreased blood amylase almost always excludes pancreatitis. Hypocalcemia is usually present and the level found is usually below nine. A flat x-ray film of the abdomen may reveal a separation of the upper and lower limbs of the duodenum brought about by an edema of the head of the pancreas. This latter finding is unusual.

RENAL COLICS

Stones are not the only substance which produce renal colics, since the same syndrome may be produced by a small blood clot, inspissated pus, uratic debris, or a kinking of the ureteropelvic junction in a ptotic kidney.

The condition is more common in males, and the patient may reveal a history of previous attacks, a hereditary influence, a story of gout, or parathyroid pathology.

The patient complains of a sudden pain which starts in the lumbar region and radiates to the testicle, vulva or the inner aspect of the thigh. With this pain he becomes extremely restless and thrashes about. A patient who is experiencing a colic is restless and moves about, but one who has a peritonitis lies perfectly quiet and resents being moved. Vomiting is a common symptom, as is a frequency of urination. During the act of micturition the pain may be altered.

Physical examination rarely reveals any elevation in temperature, but extremely

characteristic of the condition is a bradycardia. It has oftentimes been stated that when a patient with an acute abdomen has "a clean tongue and a slow pulse" he has a renal colic until proved otherwise. Tenderness is not marked in the region of the twelfth rib of the involved side, and to elicit this finding it is unnecessary and cruel to utilize any type of "punch" test. The tenderness is so exquisite that mild percussion will demonstrate it. We prefer to use the term "Murphy tap" to "Murphy punch." A zone of hyperesthesia is usually found posteriorly at the level of and slightly below the twelfth rib. If this area is anesthetized with novocaine, the hyperesthesia and pain disappear.

A flat x-ray film may reveal a stone if such is present, but this is not reliable since non-opaque substances may also produce kidney colic. An intravenous pyelogram can be made without disturbing the patient, and if necessary, the films can be taken at the bedside with the aid of a stationary grid. The significant finding for a diagnosis of a stone in the ureter is the amuria which may be present on the affected side; the opposite side shows normal excretion. The kidney on the affected side usually appears increased in density since the dye in these tubules is more concentrated. This finding is sufficient for diagnosis of non-opaque stones in the ureter. A catheterized specimen of urine usually reveals pus, blood and albumin. The presence or absence of pus and blood in the urine is not pathognomonic since a stone may completely block the ureter and result in a normal urine. On the other hand, an inflamed appendix may be attached to the ureter, kidney or bladder, resulting in a secondary ureteritis, nephritis or cystitis with an associated hematuria. In such instances the laboratory report may actually be misleading.

CORONARY DISEASE

Although this belongs to the realm of the internist, the general practitioner as well as the surgeon must be on his guard to avoid the fatal error of confusing an acute coronary disease with an acute abdominal condition.

Men are most susceptible to coronary disease, and it is found usually in those past the age of forty. A previous history of dyspnea or pain in the chest during exertion or excitement may be elicited. The attack is sudden, with severe pain in the chest which

radiates out the left arm toward the abdomen or both shoulders. There is a sense of impending death with severe fright which usually supersedes the complaint of pain. The radiation may also be toward the epigastrium, so that the examiner's attention is directed to the abdomen rather than the chest. A usual complaint during such an attack is one of "indigestion." Although the pain of acute coronary disease may occur in the abdomen, it does not become localized, hence, no area of local abdominal tenderness is ever found. Marked abdominal distention may be present in coronary pathology, but muscle defense or rectus rigidity are lacking. In abdominal catastrophes the patient lies perfectly quiet, but the coronary patient resembles the colic in that he is restless and tosses about. The acute cardiac patient presents veins in the neck which are distended and full, in contrast to the patient with the surgical abdomen who may appear pale and bloodless. Signs of impaired circulation are usually present, such as dyspnea, orthopnea, and cyanosis. Auscultation will usually reveal rales in both bases due to pulmonary congestion. Cardiac enlargement, feeble heart sounds and occasionally a pericardial friction rub may be found. During auscultation of the abdomen, normal intestinal sounds will be heard which are absent or diminished in cases of spreading peritonitis.

It should also be emphasized that a distinction should be made between acute coronary occlusion and acute coronary insufficiency. Acute coronary insufficiency presents itself as an episode of angina pectoris varying from simple transitory chest pain or pressure to severe pain or collapse. It is usually relieved by glyceryl-trinitrate. Coronary occlusion is the complete closure of an artery and is not influenced or precipitated by external environmental factors. It is not relieved by glyceryl-trinitrate, which may even aggravate it.

Positive electrocardiographic findings are pathognomonic, but one is not always fortunate enough to have an electrocardiogram handy. A leukocytosis may be present some hours after the disease takes place, and the urine is usually negative unless there is associated renal pathology.

It is realized that many other conditions at times require differentiation in the acute ab-

domen, among them strangulated hernias, regional ileitis, mesenteric lymphadenitis, mesenteric thrombosis, ruptured ectopic pregnancy, ruptured graafian follicle, ileocecal tuberculosis, vasitis, torsion of the omentum, volvulus, intussusception, etc., etc., ad infinitum. However, when one misses one of the unusual conditions he does not feel quite as responsible or guilty as he would having missed one of the forementioned "Big Six."

RECIPE FOR SUCCESS

A good recipe for a successful medical organization is found in the New England Journal of Medicine when it states that one new society charged its members with the following:

I. Campaign to increase the membership of your district society to include every eligible physician.

II. See that your councilors discuss the advance information to councilors before the meeting of the Council.

III. Make it possible for every registered physician in the district to care for his patients in an approved hospital. This is a public necessity; and act of justice to the physician who is entitled by law to practice medicine, and to his patients.

IV. Let the public know that good medical care can be obtained regardless of the patient's ability to pay.

V. So organize the professional facilities of your district that the services of a physician are available every hour in every day.

VI. Discuss the fee with the patient before the first bill is sent.

VII. Public service before financial gain.

VIII. Study the proceedings of the House of Delegates of the American Medical Association and the Council of the South Dakota Medical Association as they appear in your journals.

IX. Know the Code of Ethics.

The recipe has been adapted for readership of the South Dakota State Medical Association . . . but no matter who the author or the adaptor, it's mighty essential advice to keep-ing medicine strong.

Helpful Points in the Diagnosis and Treatment of Liver Disease*

Maurice H. Stauffer, M.D., Division of
Medicine, Mayo Clinic, Rochester, Minnesota

The purpose of this paper is to point out the outstanding clinical features for diagnosis and the few basic principles in the treatment of diseases of the liver. I should like also to comment briefly on a few of the most dependable laboratory tests and needle biopsy as aids in diagnosis. It is not within the scope of this paper to cover the details of the subject, but to discuss the landmarks of diagnosis and treatment of hepatic disease currently seen in medical practice. This subject will be divided into six headings: (1) hepatitis, (2) classification of jaundice, (3) extrahepatic obstructive jaundice, (4) cirrhosis, (5) other causes of hepatomegaly, and (6) needle biopsy of the liver.

Hepatitis

World War II emphasized the importance of hepatitis to military physicians because of epidemics among the troops of many countries. Out of these experiences came some very important data. It is now well documented that so-called catarrhal jaundice is caused by a filtrable icterogenic agent thought to be a virus. Neefe and associates,^{1, 2} Paul and associates³ and others showed by studies on human volunteers that there are many distinct peculiarities about this disease now termed "viral hepatitis." It has been said that the elucidation of this subject was perhaps the most important medical or surgical discovery during World War II. Since yellow jaundice has been a war camp follower for generations, it is only natural that there would be renewed interest in this disease since the outbreak of the Korean War, sometimes referred to as World War II½. In recent weeks there have been several newspaper articles on the small epidemic of hepatitis in Bismarck, North Dakota, which serves to emphasize the importance of this disease to physicians in this area.

It has been shown there are two forms of

this disease,³ (1) epidemic infectious hepatitis and (2) homologous serum jaundice. The most important differences in the two forms are the method of spread and the incubation period. The epidemic type is transmitted by the fecal-oral route; usually contaminated food or water is suspected but often it is hard to establish a definite relationship. The epidemics are due to a breakdown in sanitation, as appeared to be the problem recently in the Bismarck, North Dakota, area.

The other form, homologous serum jaundice, has a much longer incubation period than infectious hepatitis, 40 to 120 days; in some cases the incubation period is as long as 180 days after inoculation. This type is spread by the use of blood, blood products or contaminated needles and syringes. The use of pooled human blood plasma has been responsible for the majority of cases. The frequent occurrence of this disease during World War II, when plasma had to be used, was mostly unavoidable; however, the present indiscriminate use of this product is a regrettable chapter in American medicine. Too commonly this material is used as an adjunct to an operation, such as thyroidectomy or hemorrhoidectomy, without due indications for blood volume replacement. In my experience the incidence of this disease is just as great or greater than in 1946. The recent increase in use of plasma has probably been due to the protection thought to be afforded by the irradiation process. James and associates⁴ aptly warned that this process is ineffective in eradicating the infective agent. In the past year I have seen 3 patients in whom the evidence strongly pointed to irradiated plasma as the cause of the hepatitis. The importance of this matter is again brought to mind in considering the treatment of injuries in civilian practice and in the current Korean conflict. Certainly pooled plasma should be used only when blood is not available. All donors of blood should be rejected if there

* Read at the meeting of the Sioux Valley Medical Association, Sioux City, Iowa, February 27 to March 1, 1951.

has been a history of jaundice, since no one knows how long the virus may remain transmissible.

The diagnosis of viral hepatitis during an outbreak of the epidemic type or after the use of plasma is fairly obvious. However, when a sporadic case appears in civilian practice, establishment of the diagnosis may not be an easy matter. The onset of epidemic or sporadic hepatitis usually has a prodrome of fatigue and anorexia for one to two weeks. The appearance of jaundice is associated with a systemic reaction consisting of fever, nausea, vomiting, diarrhea and varying degrees of pain in the right upper quadrant of the abdomen. In my experience the most constant clinical symptom in hepatitis is nausea with some vomiting. This nausea is of a persistent type, lasting for several days or weeks. During the height of the disease the patient usually vomits about one meal daily. Any pressure in the right upper abdominal quadrant may exacerbate the nausea, and the patient often will say, "Food seems to stay in my throat ready to come up at any moment." The onset of epidemic hepatitis may closely resemble an attack of acute cholecystitis. The pain is more localized and severe in calculous cholecystitis than in epidemic hepatitis; nausea and vomiting may occur, but persistent daily nausea is not the rule.

In contrast the onset of serum jaundice is more subtle than that of epidemic hepatitis, usually without fever, diarrhea or abdominal pain. It might be said that this insidious beginning is similar to that of a benign stricture of the common duct weeks or months after an operation on the biliary tract. Despite the rather innocent onset in serum jaundice, it packs a greater punch with a mortality of 10 to 20 per cent as compared with less than 1 per cent for the epidemic variety. If a patient becomes jaundiced 40 to 180 days after the administration of plasma, the diagnosis and treatment should be that of serum jaundice until the evidence is overwhelmingly to the contrary. In hepatitis if the icterus is visible there will be dark-colored urine due to the presence of bilirubin. Often the patient may think the urine contains blood. During the course of either form of hepatitis there may be one period when the stools are light or acholic, but this stage

usually lasts only four to seven days. This might be called the "bile suppression" phase of hepatitis.

In the great majority of cases, the degree of jaundice runs a steady crescendo and decrescendo course. This is important in that any definite wide fluctuation of the icterus should make one wary about the diagnosis of hepatitis and suggests that the jaundice may be obstructive. The patient's own appraisal of the day-to-day intensity of the icterus is not trustworthy. The occurrence of ascites and edema is strong evidence for parenchymal hepatic disease and is seen in a small percentage of patients with hepatitis. Although this is an ominous sign it need not mean a fatal outcome, for some patients recover. I have dwelt on these clinical features, since they may lead one to suspect the correct diagnosis when complicated laboratory tests are unreliable or not obtainable.

The thymol turbidity test developed in 1944 by MacLagen of London is in my experience the best laboratory procedure to confirm a suspected case of viral hepatitis. There are very few false positive reactions in obstructive jaundice. In a series of 42 cases of surgically proved extrahepatic obstructive jaundice studied by Crumpacker, Dockerty and myself,⁵ only 2 had false positive thymol turbidity reactions and both of these were only 5 units. These 2 patients had long-standing obstruction of the common duct, and most likely there was mild secondary biliary cirrhosis. The upper limit of normal for our laboratory is 4 units. The thymol turbidity may be abnormal in patients with rheumatoid arthritis, lupus erythematosus and of course in cirrhosis, but when the clinical features suggest hepatitis, a positive thymol turbidity reaction is strong confirmatory evidence. Furthermore, the more positive the test, such as values between 10 and 30 units or greater, the more likely it is that the patient has parenchymal hepatic disease. Surgical exploration in cases with positive and especially strongly positive thymol turbidity reactions will result in much disappointment and some fatalities. There are relatively few false positive thymol turbidity reactions, but there are many more that might be called false negative reactions; that is, there are 10 to 25 per cent of patients with hepatitis who have negative so-called flocculation reactions.

By this latter term is loosely meant the thymol turbidity, zinc sulfate turbidity and cephalin-cholesterol tests.⁶ The negativity of these reactions in certain cases makes the clinical appraisal a more important feature. In a situation in which the diagnosis is uncertain, it is wise to procrastinate before advising exploration of the biliary tract. During this "cooling off" period, hepatitis may miraculously subside. The hepatic damage caused by several weeks of extrahepatic obstructive jaundice is quickly reversible after surgical correction. This philosophy was expressed by Dr. W. J. Mayo in 1918 when, during a bout of jaundice, he said: "I have either a cancer of the liver or a benign condition that will clear in sixty days."

The treatment of viral hepatitis is a simple matter. The patient should be kept at rest in bed and on an adequate diet until the jaundice has cleared. Experience has shown that ambulant patients have a delayed convalescence and are more prone to recurrences than those who are kept in bed. Bradley⁷ has advanced the idea that hepatic blood flow is more adequate in the recumbent position than in the erect position. Intravenously administered solution of glucose and added vitamins are perhaps helpful but not absolutely necessary unless the patient is vomiting. Lipotropic agents such as methionine and choline are of no value. Paracentesis is to be avoided. The most recent question about treatment has been concerning the value of aureomycin and chloramphenicol. Early reports about their efficacy in viral hepatitis are discouraging. After the jaundice has subsided, the sulfo-bromophthalein liver function test is the best procedure for following the return of hepatic function to normal.

Classification of Jaundice

Although my subject for this talk is primary hepatic disease, it is necessary to include comments about problems of differential diagnosis. No discussion on this subject can be given without using some classification of jaundice. In 1923 McNee divided jaundice into three groups: (1) hemolytic, (2) toxic or infectious, and (3) obstructive. Rich used only two main groups, retention and regurgitation jaundice. More recently Ducci⁸ advanced a classification that has gained much attention by using terminology suggesting the pathogenic location of the jaundice; namely,

prehepatic, hepatic and posthepatic. For this talk I should like to refer to the three fundamental groups of jaundice under the headings of types I, II and III, mentioning the terms commonly used to denote each variety.

Type I.—This is used to include the category usually called "hemolytic jaundice," but more adequately named "retention jaundice" by Rich or "prehepatic jaundice" in Ducci's classification. The defect in this type of jaundice is related to the formation and excretion of bilirubin before it reaches the liver or more specifically the hepatic cells. The most frequently seen examples of this type are constitutional hepatic dysfunction and hemolytic jaundice of both the congenital and acquired forms. The serum bilirubin giving the icterus is of the indirect type as determined by the van den Bergh reaction, and does not pass into the urine, a feature which gives this type still another synonym, "acholuric jaundice." The simplest clinical rule to follow is that in this group the urine and stools do not change color. It also should be noted that since the icteric index is a colorimetric test, it does not distinguish direct and indirect bilirubin; therefore this test alone is not adequate to establish the diagnosis of prehepatic jaundice. Recently I saw a student, aged 20 years, with jaundice who had spent six months in bed with a presumptive diagnosis of hepatitis. The jaundice had been confirmed by an icteric index of 50 units. The serum bilirubin determination was 5 mg. per 100 cc. but it was all of the indirect reacting type, thus establishing the diagnosis of constitutional hepatic dysfunction, since other tests ruled out hemolytic jaundice.

Type II.—This is used to denote the variety of jaundice in which the disease causing the icterus is within the liver and has been designated by many terms such as "parenchymal," "hepatic," "hepatogenous," "medical," "intrahepatic," "toxic," "infective," "intrahepatic obstructive," "nonobstructive" and "regurgitation jaundice." (The latter term is subdivided into two types under Rich's classification.) Viral hepatitis and cirrhosis are the commonest causes of this form of jaundice. In this type bile is regurgitated back into the blood within the liver, or reaches the blood indirectly via the lymphatics. Since the bilirubin has crossed the hepatic cell it gives the direct van den Bergh reaction. Somehow

medical students commonly gain the impression that in hepatitis the bilirubin is indirect, which is of course erroneous.

Type III.—This is used to categorize the group that most physicians call "obstructive jaundice," or more correctly "extrahepatic obstructive jaundice," caused by mechanical obstruction of the bile ducts outside the liver. This also has been referred to as a mechanical type of regurgitation jaundice or posthepatic jaundice (by Ducci), implying that the pathologic lesion is in the biliary tract beyond the liver. "Surgical jaundice" is another name, since the lesions are usually amenable to operative correction. In this form of jaundice the bilirubin gives the direct van den Bergh reaction, the same as was noted under type II, in which the disease is intrahepatic.

Extrahepatic Obstructive Jaundice

Now I should like to discuss the important diagnostic features of the common lesions causing extrahepatic biliary obstruction. The lesions most frequently encountered are stone in the common duct, stricture of the common duct and carcinoma of the pancreas or papilla of Vater. The facts given in the patient's history are very important in this group, since often the laboratory data are inconclusive. Stone in the common duct should be suspected if any patient gives a history of upper abdominal painful seizures, associated with chills, fever and jaundice, and especially if these episodes have been intermittent, the original attack dating more than one year in the past. Other than the presence of jaundice the physical examination and laboratory data are often not helpful except for their negativity. Fluctuating icterus should make one suspect a ball-valve obstruction of the common duct. Quite commonly after a previous attack of pain without jaundice a cholecystogram may have been made which revealed gallstones or the patient will say, "I was told the gallbladder did not cast a shadow." A plain film of the abdomen may show radiopaque gallstones, and rarely this technic will reveal the shadow of a stone in the common duct. Occasionally a plain film of the upper part of the abdomen will reveal pancreatic calcification, thus clarifying the etiology of the jaundice.

Unfortunately, surgical injury to the common duct at the time of cholecystectomy with subsequent formation of stricture is indeed

a tragic affair. Jaundice occurring in the postoperative period suggests this complication but it so happens that the "incubation period" of a stricture may be the same as for serum jaundice, approximately 40 to 180 days. Therefore we might say that any patient who becomes jaundiced 40 to 180 days after cholecystectomy who did not receive blood or plasma, and who did not have preoperative jaundice, should be considered to have a stricture. However, any patient who becomes jaundiced 40 to 180 days after cholecystectomy and has had plasma presents quite a problem, since serum hepatitis and stricture are both good possibilities. Fever, chills and a fluctuating course will favor the diagnosis of a stricture. Laboratory data such as positive thymol turbidity will favor the diagnosis of hepatitis. In this set of circumstances, large doses of procrastination should be prescribed. Obtaining the history of profuse bile on the dressings in the immediate postoperative period after simple cholecystectomy should make one suspicious that the common duct has been injured and the groundwork for a stricture may have been laid.

Carcinoma of the papilla of Vater is not a rare lesion. Historically this tumor may simulate a stone in the common duct with upper abdominal pain, fever, chills and fluctuating jaundice, but with a course of less than one year in duration. These papillary carcinomas often bleed grossly, giving melena, or fresh blood may be found on duodenal drainage. This latter finding is commonly the most important evidence for this lesion. A classic pattern for an ampullary carcinoma would be a nine month history of intermittent chills, fever and jaundice, with one episode of melena, all ending with the development of a palpable gallbladder. Since radical resection of this lesion is becoming more successful it is important to suspect the diagnosis and plan this type of operation. Duodenal drainage for the presence or absence of bile and fecal urobilinogen are of little value in differentiating between stone in the common duct, stricture and an early ampullary carcinoma, since the obstruction is usually incomplete.

The painless onset of jaundice and a palpable gallbladder almost certainly indicate carcinoma of the head of the pancreas. Painless jaundice without a palpable gallbladder

is a more difficult problem. If it can be established that the bile ducts are occluded, it is the most important evidence for malignant obstruction. A fecal urobilinogen of less than 5 mg. per twenty-four hours or absence of bile on duodenal drainage is usually confirmatory for pancreatic carcinoma. Only rarely will a common duct stone produce complete obstruction. Painless jaundice with incomplete obstruction of the common duct should always make one duly consider viral hepatitis as a possibility. Recently Miller and associates⁹ have observed that in carcinoma of the head of the pancreas pain is noted more commonly than has previously been considered.

Cirrhosis

Cirrhosis is a disease with such variable signs and symptoms that it often presents a diagnostic problem. The liver may be large or small; there may or may not be ascites and edema; the serum proteins may be greatly deranged or normal; the results of other so-called tests of hepatic function may be normal or abnormal; the spleen is palpable in about one third of the cases,¹⁰ and the presence of jaundice is a variable finding. The diagnosis of cirrhosis should never be made merely on the finding of an enlarged liver and jaundice. Actually, jaundice is not very common in cirrhosis except in the acute episodes of the alcoholic variety and in some cases of primary biliary cirrhosis. The observation of cutaneous vascular "spiders" associated with a large liver is one of the most reliable clinical signs of cirrhosis. The demonstration of esophageal varices is equally confirmatory, and evidence of collateral venous circulation is helpful. The presence of ascites and edema is suggestive of this diagnosis, but this finding is certainly not specific since it is noted in other conditions such as cardiac decompensation and malignant abdominal lesions. In the absence of other obvious findings the determination of venous pressure is an important procedure in making the differential diagnosis between cardiac failure and cirrhosis. This problem of distinction between these two diseases is frequently encountered.

In the absence of jaundice the sulfobromophthalein dye excretion test is the time-honored measure of hepatic dysfunction. In many patients with cirrhosis it may be the only abnormal test of liver function. Rarely a pa-

tient with cirrhosis will have a normal sulfobromophthalein test. In most laboratories determination of the serum proteins with partition of the albumin and globulin fractions is reliable. Lowering of the serum albumin with reversal of the albumin-globulin ratio is excellent evidence of primary hepatic disease, but certainly is not ironclad. An abnormal thymol turbidity favors cirrhosis, since this finding is rare in metastatic carcinoma and obstructive jaundice. The zinc sulfate turbidity is more often positive in cirrhosis than the thymol turbidity.

Now that needle biopsy of the liver is being more widely employed, it is an excellent method to establish a diagnosis of cirrhosis. I shall comment more about this later.

Although it has been said there is only "one cirrhosis" there are many discernible differences in individual cases. Recently in studying a series of 58 cases of cirrhosis it was helpful to divide them into five groups based on a combination of clinical, laboratory and needle biopsy information. It would seem that from the standpoint of etiology and prognosis, division into these groups is of value. These are (1) typical portal cirrhosis (Laennec's), (2) portal cirrhosis (fatty type), (3) postnecrotic cirrhosis, (4) primary biliary cirrhosis, and (5) obstructive biliary cirrhosis. This is not an arbitrary classification, since many cases will not fall readily into these groups.

Under typical portal cirrhosis is included for example the hepatic disease seen in advanced so-called Banti's disease. The final stage in any type of cirrhosis may pathologically resemble typical portal cirrhosis.

Portal cirrhosis (fatty type) or fatty cirrhosis is used to include those cases with large amounts of fat in the specimens obtained by needle biopsy. We might be justified in calling this group alcoholic cirrhosis, since 13 of 14 patients in this type had been heavy drinkers. Some object to the term "alcoholic cirrhosis." However, anyone who has seen a large group of cirrhotic patients will not deny that the use of alcohol seems to be a common factor in many cases.

Postnecrotic cirrhosis is a term gaining favor to describe the coarsely nodular, atrophic liver seen as a sequela of severe viral hepatitis. This diagnosis is difficult to make for certain on the basis of the needle biopsy

specimens, and not all pathologists are in agreement about this entity, despite necropsy studies. Although many cases do not have all the pathologic criteria it is a useful term to denote this postviral group. Actually this complication of hepatitis is rare, and one should be careful in making this diagnosis. There is no question in my mind but what there is a postviral cirrhosis, but this diagnosis is much more certain if the patient can be followed clinically from an acute attack of viral hepatitis into the stage of chronic decompensation, and still more authentic if proved by necropsy.

Under primary biliary cirrhosis is included a heterogeneous group who have low-grade jaundice, pruritus, hepatosplenomegaly without ascites and minimal disability. For many years this syndrome was referred to as "Hanot's cirrhosis." Laboratory studies often show an elevated alkaline phosphatase and a hyperlipemia. In many cases cutaneous xanthomas develop. Some of these cases have had an onset in what appeared to be viral hepatitis and then gradually go into a mild chronic course; but many patients with this clinical and laboratory syndrome have not had hepatitis and one can only speculate about the etiology.

If the term "posthepatitis cirrhosis" is used, I would suggest that it include all cases of viral etiology, thus denoting postnecrotic cirrhosis and primary biliary cirrhosis (some cases) as two subtypes of posthepatitis cirrhosis. It should also be mentioned that there are cases of posthepatitis cirrhosis that are clinically and pathologically indistinguishable from typical portal (Laennec's) cirrhosis.

Obstructive biliary cirrhosis is the type seen after prolonged obstruction of the biliary tract, and its most frequent cause is a stricture of the common duct. Rarely this type of cirrhosis is produced by low-grade intermittent obstruction due to a stone in the common duct. It is almost never seen in malignant obstruction of the common duct, since the tumor usually causes death of the patient before cirrhosis has time to develop.

Now turning to the treatment of cirrhosis, we must all face the facts. The outlook for a patient with well-developed cirrhosis is discouraging. There is no magic way to remove fibrous tissue from the liver. Of the five types of cirrhosis mentioned there are two in which

the process may be partially reversible and the outlook fairly good. In an early obstructive biliary cirrhosis caused by a stone or stricture of the common duct, correction of the offending lesion will often dramatically change the process. The other type with potential reversibility is the fatty cirrhosis associated with alcoholism. Many patients in whom ascites and edema have disappeared with development of a "compensated" state or the so-called cures have had this fatty type. Occasionally these patients may have just a severe fatty metamorphosis, and obviously the prognosis is better than when there are well-advanced regenerative nodules. The future of these patients is essentially related to their alcoholic and dietary intake. This is the group in which the lipotropic agents, choline and methionine, should theoretically be of value. Some studies have shown dramatic disappearance of the fat from the liver while the patient is receiving these agents. However, adequate controls have not been used to show that this would not happen when the patient is treated with an adequate diet and abstinence from alcohol.

The prognosis in advanced portal and postnecrotic cirrhosis is most discouraging. Patients with primary biliary cirrhosis may remain "compensated" for a number of years, but esophageal varices and osteoporosis tend to develop.

Everyone is now reasonably well agreed that the diet of choice in cirrhosis is the high carbohydrate, high protein, moderate fat regimen with added vitamins as advised by Patek¹¹ in 1937. The beneficial effect of the low sodium regimen in controlling ascites and edema in some patients is also now established. The absence of salt, however, often makes the diet unpalatable and causes the patient to lower the caloric intake. Patients continued on this program should be watched for the "low salt syndrome" with symptoms similar to those of Addison's disease. Paracentesis, of course, should be used if needed. A few patients respond well to mercurial diuretics, which should be used as indicated.

The management of esophageal varices in cirrhosis is a highly controversial problem. Many surgical procedures have been attempted to control this type of hemorrhage. Recent reports of Blakemore¹² on the results of the direct portacaval shunt sound most

encouraging. I feel we are entering a phase during the next five or ten years when portacaval shunt is going to be tried extensively, and it may take that long to evaluate the procedure.

Other Causes of Hepatomegaly

Metastatic carcinoma of the liver is one of the commonest causes of an enlarged liver. This entity should always be suspected when there is or has been malignant tumor in another organ of the body. A physician is usually "bucking the tide" when attempting to make a separate diagnosis in this set of circumstances. In my experience malignant tumors of the stomach, colon, lungs, gallbladder and breasts are especially likely to cause hepatic metastasis. The old rule of an artificial eye plus a large liver suggesting metastatic melanoma rarely fails the observing clinician. A nodular liver on palpation is an important observation when a metastatic lesion is suspected. The sulfobromophthalein dye excretion test is the most valuable procedure when screening for metastatic hepatic disease. When there is a significant degree of dye retention noted in a patient with or without hepatomegaly, metastatic carcinoma is always to be considered. Other so-called tests of hepatic function are rarely of value except for their negativity. Needle biopsy has been of tremendous value in confirming this diagnosis. For instance in a group of 90 patients who had malignant lesions in the liver, we obtained a positive result of biopsy in 70 cases. It often saves the patient a laparotomy with prolonged hospitalization.

In any patient with hepatomegaly and ascites, constrictive pericarditis should always enter the differential diagnosis. The syndrome of ascites without peripheral edema is often an overlooked feature in this entity. Pericarditis may be suspected from a history of low-grade ascites that waxes and wanes over a period of several years. Observation of distended neck veins and determination of venous pressure will usually confirm the clinical suspicion. Too commonly these cases have been called Laennec's cirrhosis.

Hepatomegaly associated with diabetes and bronzing of the skin usually means hemochromatosis. However, this diagnosis should be suspected from hepatomegaly alone when the cause is not obvious. For instance out of a group of 9 cases in which diagnosis of hemo-

chromatosis was established by needle biopsy of the liver several were clinically unsuspected. Recent reports of Davis and Arrow-smith¹³ about the results of the repeated venesection as treatment of hemochromatosis seem encouraging. Amyloidosis should be suspected when there is hepatomegaly in a patient with tuberculosis, rheumatoid arthritis or a chronic suppurative disease. However, hepatic involvement is noted in so-called primary systemic amyloidosis. The Congo red and Paunz tests are of value in confirming this suspicion. Needle biopsy of the liver will often prove the diagnosis. Congenital cystic disease of the liver is another cause for hepatomegaly. Usually the result of the sulfobromophthalein liver function test is nearly normal and the hepatic enlargement will have been noted for several years. Congenital cystic kidneys may be associated with this entity and will help to confirm the suspected diagnosis. Palpation of these cysts on the surface of the liver may give one the erroneous impression that they are metastatic nodules.

Needle Biopsy of the Liver

My colleagues, Drs. Dornberger and Dockerty, and I¹⁴ have done more than 400 successful needle biopsies of the liver. We have used the Silverman needle exclusively. A core of liver tissue about 2 mm. wide and 2 cm. long is obtained. If the liver is enlarged, the biopsy is performed below the right costal margin; if the liver is barely enlarged or not palpable, the intercostal transthoracic approach in the anterior axillary line is used. Fortunately we have had no deaths in this series and only a few severe reactions. Most of the reactions have been due to a bile peritonitis, and we have not encountered any severe hemorrhages. No patient has had to have a blood transfusion, and only 1 has had to undergo surgical exploration, at which time nothing definite was found, except a mild peritoneal reaction, to explain the prolonged pain. We have found the method most valuable in proving the diagnosis of metastatic carcinoma of the liver. Often multiple biopsies are taken to increase the chance of striking a localized nodule.

Cirrhosis of the liver is usually readily identifiable by needle biopsy. In a few instances the tissue has been inadequate to show nodular regeneration that large wedge

biopsies would have revealed. Ordinarily the diagnosis of viral hepatitis can be established by liver biopsy; however, in some cases the pathologic interpretation is very difficult. One of the most interesting phases of this method has been a study of the histologic features of the liver in extrahepatic obstructive jaundice. Usually this condition can be determined by study of the biopsy specimen; however, in some cases the findings are indefinite and differentiation cannot be made between intrahepatic and extrahepatic obstructive jaundice. Such diseases as hemochromatosis, amyloidosis and fatty liver can definitely be diagnosed by the needle biopsy method. We have failed to obtain tissue in about 3 per cent of the cases attempted. Included under contraindications for biopsy are an elevated prothrombin time, evidence of peritonitis or hepatic abscess, marked ascites, unco-operative patients, thrombocytopenia, and infections of the right pleural cavity.

SUMMARY

Viral hepatitis continues to be a common disease in both civilian and military practice. The indiscriminate use of plasma produces a steady stream of patients with serum jaundice. The majority of cases of hepatitis encountered seem to be of the sporadic variety, but there is an occasional small epidemic such as the one that recently occurred in the Bismarck, North Dakota, area. Persistent daily nausea is a prominent symptom of hepatitis, and the thymol turbidity reaction is positive in the majority of cases. The treatment of this disease is rest in bed and an adequate diet.

Etiologically there are three fundamental types of jaundice. Under type I are included the forms variously called "prehepatic," "retention" or "hemolytic jaundice." Hemolytic icterus and constitutional hepatic dysfunction are examples of this type. Type II is used to denote the intrahepatic form of jaundice, of which hepatitis and cirrhosis are examples. Type III is produced by obstruction of the biliary tract outside the liver, and is commonly called "extrahepatic obstructive jaundice." The usual causes of this variety are stone or stricture of the common duct and carcinoma of the pancreas or papilla of Vater.

It is important to differentiate the intrahepatic and extrahepatic forms of jaundice,

since surgical exploration of the former group is a dangerous procedure. Stone and stricture of the common duct can usually be suspected from certain data in the patient's history. Carcinoma of the head of the pancreas can be suspected from a palpable gallbladder or by establishing that the bile ducts are occluded by an absence of bile on duodenal drainage and by studies of the fecal urobilinogen.

Cirrhosis of the liver is often a difficult disease to diagnose. Observation of cutaneous vascular spiders and demonstration of esophageal varices are two important confirmatory findings. The sulfobromophthalein liver function test and determination of the albumin-globulin fractions of the plasma are the most helpful laboratory tests. Using clinical, laboratory and biopsy information, the majority of cases of cirrhosis can be divided into five types: (1) typical portal cirrhosis (Laennec's), (2) portal cirrhosis (fatty type), (3) postnecrotic cirrhosis, (4) primary biliary cirrhosis, and (5) obstructive biliary cirrhosis. There are apparent differences in these groups from the etiologic and prognostic standpoints. Although dietary management seems beneficial in some cases of cirrhosis, the therapy in many instances is discouraging. If the patient with early fatty cirrhosis will abstain from alcohol and follow a dietary regimen, the outlook is fairly good.

Metastatic carcinoma of the liver can be suspected in patients who have or have had malignant lesions in other parts of the body. The palpation of hard nodules on the surface of the liver is most suggestive of a metastatic lesion. Other causes of hepatomegaly are cardiac failure, hemochromatosis, amyloidosis and constructive pericarditis.

Needle biopsy of the liver is a useful diagnostic aid in diseases of the liver. It is of value in establishing the diagnosis in metastatic carcinoma, cirrhosis, hepatitis, hemochromatosis and amyloidosis. It is also of value in the differentiation between viral hepatitis and extrahepatic obstructive jaundice, but commonly this distinction is not clearly discernible histologically.

REFERENCES

1. Neeffe, J. R.: Recent Advances in the Knowledge of "Virus Hepatitis." *M. Clin. North America*. 30:1407-1443 (Nov.) 1946.

(Continued on Page 249)

The Care of the Cardiac Patient Undergoing Surgical Treatment*

Raymond D. Pruitt, M.D.
Division of Medicine
Mayo Clinic, Rochester, Minnesota

It is in the natural course of events that when more prevalent dangers are met and eliminated, attention is directed to less common sources of trouble. In our own lifetime, we have seen progress in surgical technic, the development of antibiotic agents, and the emergence of the science of anesthesia reduce to the point of elimination those complications which once accounted for the majority of deaths in the immediate postoperative period. As a result, two things have happened. First, greater attention has been focused upon the management of those constitutional disorders the existence of which may imperil the outcome of a surgical venture. Second, the patient afflicted with such a constitutional disorder has been accepted for surgical treatment when it is indicated, whereas he would have been denied it in an earlier day. Competence has led to boldness, but that boldness may prove folly unless it is matched by ever-increasing knowledge and ever-increasing care for detail.

Among those who participate in the management of the surgical patient, the cardiologist occupies a position of growing importance. This should not be regarded as a tribute to the abilities of the cardiologist, for all it implies is that he, to a greater degree than his fellows within the field of internal medicine, has failed to master **his** problems, and hence his patients **remain** problems to anyone else who from time to time must participate in their care. If he could match in effectiveness the metabolic consultant who controls so precisely the reactions of the diabetic patient, the care of the cardiac patient undergoing surgical treatment would be reduced to a formula about which even the most resourceful could not make a speech. The cardiologist, like the rank amateur in golf, puts on an interesting performance be-

cause he makes so many surprisingly bad shots.

The Preoperative Period

The care of the cardiac patient undergoing surgical treatment begins in the preoperative period. The initial problem is the nature of the cardiac disorder. At this point, the so-called expert is confronted with the intriguing possibilities for impressing his listeners with a review of the latest, the most complicated, and the most diabolic procedures coming out of laboratories for medical science, designed, it is said, to clarify the diagnostic problem. But you would not be fooled. What should concern us most about the patient who needs surgery is how much his heart can do before symptoms of failure or limited reserve put in an appearance. The patient himself must tell us this, and not the results of the most technical of studies.

When certain types of cardiac disease are present, the potentialities of the lesion lie almost wholly within this tangible realm of failure of the heart to carry the work load. This is particularly true of patients who have uncomplicated hypertension or those with any other lesion the principal consequence of which is to increase the stress on the left ventricle. Pathologic processes of this type do not constitute the source of frustration which is encountered in a second category of disorders in which the risk is in large measure of an intangible sort. Commonest representative of this latter group is disease of the coronary arteries. Here, the principal advantage of arriving at a diagnosis is that patient and surgeon approach the operation fully aware of the increased danger, but unfortunately relatively impotent to reduce the risk — a situation about as rewarding as that of that fine old lady who sought the services of a physician noted for his diagnostic acumen because, as she put it, she "wanted to be sure to die of the right disease."

We may bring these rather general con-

* Read at the meeting of the South Dakota State Medical Association, Aberdeen, South Dakota, June 3 to 6, 1951.

siderations concerning the preoperative period to a focus on three specific questions.

1. Do the signs or symptoms or both of congestive failure exist? If so, then it is imperative to do all which can be done to restore compensation before surgical treatment is undertaken. This may require hospitalization with institution of the standard measures of digitalization, use of mercurial diuretic agents, and restriction on the intake of sodium. However, an effort should be made to keep the patient as active as possible during this interval.

2. In the absence of congestive failure, has the patient signs or symptoms of a definite reduction in his myocardial reserve? Perhaps paroxysmal nocturnal dyspnea is the most significant of these indications, primarily because it is more likely to escape notation by the patient. If evidence of impaired reserve is elicited, then a decision must be made whether to give or to withhold digitalis. A rather lenient attitude is permissible on this issue because of the availability of preparations for effecting digitalization rapidly and relatively safely by the intravenous route.

3. If the patient has coronary disease, is there evidence of an unstable state within the coronary circulation which might eventuate in myocardial infarction or has resulted in such infarction within the recent past?

Report of Cases

Case 1.—The patient was a white man 57 years old who had experienced episodes of severe upper abdominal pain on several occasions during the year prior to his admission to the Mayo Clinic in October, 1950. The earlier attacks were characteristic of the pain of gallbladder colic. Roentgen-ray studies disclosed a nonfunctioning gallbladder containing stones. However, one attack of pain had occurred in August, 1950, when the patient was exerting himself strenuously. So far as the patient was able to recall, this attack had been in no way distinctive from his earlier episodes of pain. His electrocardiogram, recorded on October 24, 1950, (fig. 1) disclosed changes indicative of infarction of the anteroapical region of the left ventricle complicating a right bundle-branch block pattern. The time of occurrence of the infarction could not be ascertained from the electrocardiogram, but the changes were consistent with a subacute or healing lesion. The

patient was advised to postpone cholecystectomy for a period of two or three months. Re-examination in April, 1951, disclosed that his electrocardiographic pattern had reverted toward a more normal configuration, especially with respect to RS-T segment and changes in the T wave in the precordial leads. Cholecystectomy was carried out at this time and the patient's postoperative course was uneventful.

Although the foregoing single case proves nothing, it illustrates a situation in which surgical procedure, more or less elective, was justifiably postponed because of clinical and electrocardiographic evidence suggestive of a recent myocardial infarction.

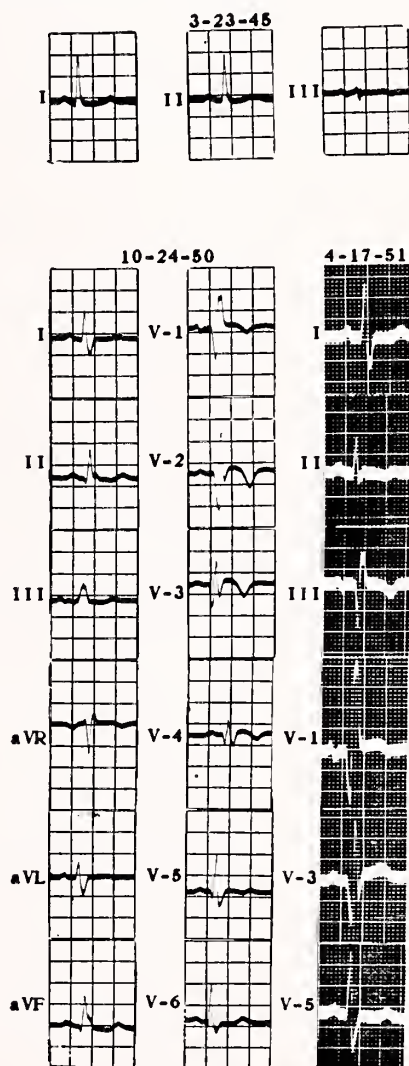


Figure I

Case 2.—The patient was a white man 50 years old who came to the clinic in April, 1951, because he had been experiencing attacks of pain in the substernal region for

about a month. Certain of these episodes had been precipitated by exertion and had been relieved, although not too promptly, by rest. Others had awakened him from sleep, forced him to sit up in bed, and persisted as long as thirty to sixty minutes. Results of an electrocardiogram recorded on April 21, 1951, were within normal limits (fig. 2). Nonetheless, the clinical diagnosis was maintained that the patient had pain related to relatively severe coronary insufficiency. Because of the short duration of the patient's illness and the persistent character of his nocturnal attacks of pain, there was reason to believe that some portion of the myocardium might well be in the state of "impending infarction."

Physical examination revealed a carcinomatous lesion of the rectum. Immediate surgical treatment appeared to offer the only chance of cure. Resection of the lesion was accomplished on May 2, 1951.

As the patient recovered from anesthesia, he complained of severe substernal pain. The course during the days which followed was that of acute myocardial infarction attended by shock. An electrocardiogram on May 3, 1951, showed changes typical of infarction in the anteroseptal portion of the left ventricle. The patient died on May 6, 1951.

In the foregoing instance an imperative surgical procedure was undertaken in the face of coronary disease of rather ominous character. Myocardial infarction occurred and terminated the patient's life. To have undertaken an elective surgical procedure under similar circumstances would have been a grave error.

The Operative Period

The time during which the patient is undergoing the surgical procedure is a critical one, yet from the cardiologist's standpoint there are few problems which are peculiar to this phase, and those which exist are the responsibility primarily of the surgeon and the anesthetist. One simple generalization which is fundamental in the handling by the anesthetist of the patient with cardiac disease is this: the depth to which anesthesia is carried is an issue of greater importance than the nature of the specific agent by which that anesthesia is accomplished. In the patient who is a poor risk from the cardiac stand-

point, excessively deep anesthesia must be avoided. The maintenance of a satisfactory oxygen tension in the mixture of gases administered to the patient with cardiac disease is an obvious requirement.

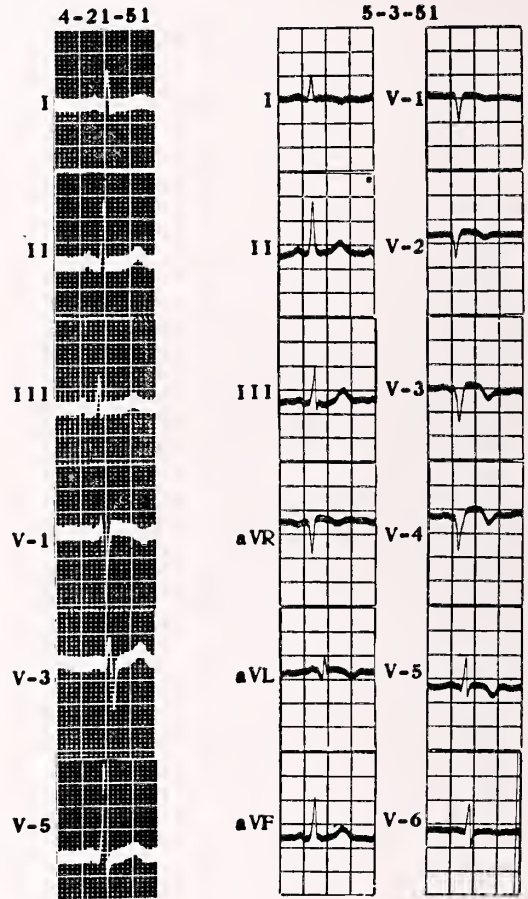


Figure II

The Postoperative Period

The problems of the postoperative period are those most likely to tax the resourcefulness of the physician responsible for the care of a patient who has cardiac disease. At this juncture, the calculated strategy may be disrupted by any one of many developments, which, while not unanticipated, may have been unavoidable. Let us consider a few of these possible complications.

Acute Decompensation With Pulmonary Edema.—The time of predilection for this catastrophe is the period of two or three days immediately after the operation. If progress is satisfactory in all other respects, acute failure is unlikely after this immediate postoperative period; but at any time the stage may be set for its appearance by the development of sepsis or the occurrence of an embolic accident. Certain of the most distressing of

my experiences with acute failure in the postoperative period have occurred in relatively young patients with mitral stenosis. The brittle character of the cardiac reserve in certain of these patients is a most distressing feature. Their lungs are placed precariously between the driving force of a competent right ventricle and the obstructed gateway of the mitral valve. Sometimes the delicate balance among the physiologic checks and counterchecks is upset by so minor an aberration as the injudicious intravenous administration of fluids. The resolution of this crisis calls for immediate and sometimes drastic action. Contrary to the layman's usual concepts, few situations exist in the treatment of heart disease which demand this kind of action. This is one of them. The objectives of treatment are, first, to increase the efficiency of cardiac action and, second, to reduce, temporarily at least, the cardiac load. The first objective is pursued by the administration of oxygen and digitalis, and the second by curtailing the venous return by the application of tourniquets or by phlebotomy. How much digitalis should be given must be determined on an individual basis. If the patient has not been digitalized preoperatively, then 1.2 mg. of one of the crystalline glycosides should be given intravenously. If the patient already has been digitalized, then 0.8 mg. of a similar preparation may prove an average dose. Since the need is for a rapidly acting drug and since adequate dosage is imperative, the desirability of giving a form of digitalis which is rapidly excreted is evident, because any toxic effects invoked by pushing administration to high levels will be short-lived. Lanatoside C or cedilanid is a suitable preparation, so far as these requirements are concerned. Reference may be made to the work of Ray and LaDue¹, who gave to all patients entering on their hospital service in a state of congestive heart failure, 1.2 mg. of cedilanid irrespective of whether or not they previously had received digitalis. They encountered no serious reactions of toxicity as a consequence of this practice.

Recently, it was my responsibility to look in on a young woman who had undergone cholecystectomy. Postoperatively, acute pulmonary edema developed secondary to mitral stenosis. Appropriate measures, including the

intravenous administration of 1.2 mg. of cedilanid, were instituted. Forty-five minutes later the patient's condition remained critical. A suggestion that 0.4 mg. more cedilanid be given was misunderstood, and an additional 1.2 mg. of the drug was given. The turning point in this critical situation occurred some fifteen minutes later, with steady improvement in the condition of the patient thereafter. I am still wondering if the excessive dose of cedilanid may not have saved the life of this patient. In the face of a similar situation, however, I would favor a more conservative approach, with increments in the dose of the drug not in excess of 0.4 mg. every forty-five to sixty minutes after an initial digitalizing dose.

Embolic Complications.—The prevention of embolic complications is so much more desirable than any form of therapy which can be applied after the event, that attention properly may be directed toward the problem of prophylaxis. Measures are now at hand by which reasonably adequate anticoagulant effects can be maintained. The crucial problem in the postoperative patient is when to institute treatment with heparin or dicumarol or both without undue risk of provoking hemorrhage. The answer to this problem hinges directly upon the nature of the surgical procedure. If an appreciable area of tissue has been left in a state of uncertain hemostasis, then anticoagulant therapy may have to be postponed, even when the need for it is painfully evident. Some few months ago, a patient whom we were observing underwent mitral commissurotomy in the treatment of severe mitral stenosis. Several months prior to her operation, she had experienced occlusion of a major artery in the left leg as a consequence of an embolus. We were fully aware of the hazard, which could only increase in the postoperative period. On the fourth postoperative day, with all going well, we decided to postpone for twenty-four hours institution of anticoagulant therapy. Within that period, hemiplegia and aphasia developed, secondary to cerebral embolism. There is no adequate resolution of these dilemmas. One can only suggest that in the susceptible patient, therapy be started as soon as any inordinate risk of provoking hemorrhage seems resolved.

Arrhythmias.—Treatment of cardiac ar-

rhythmias is, under the simplest of circumstances, a rather uncomfortable assignment. No drug is uniformly adequate in the control of any one of the several major disturbances in rhythm, and that drug which possesses the widest range of effectiveness, namely quinidine, has a singularly unsavory reputation. That bad name may be derived from an excess of emphasis upon misfortunes rare in occurrence and truly coincident in nature, but the physician who has borne the consequences of such an accident retains a distaste for use of the drug which blunts his enthusiasm in the treatment of all arrhythmias. Furthermore, in the majority of instances, he can justify a course of treatment by neglect, because he knows the patient will live out his allotted time in spite of recurring bouts of the arrhythmias.

However adequate may be the justifications, under ordinary circumstances, for this medical outcropping of a policy of *laissez faire*, they do not obtain during the postoperative period. Two basic elements have been altered. First, the patient is in a state in which he needs the greatest cardiac reserve which he can possibly maintain. Second, the arrhythmias of the postoperative period are particularly likely to be of a serious type, either by virtue of their site of origin (ventricular tachycardia) or because of their persistent character.

The incidence of auricular fibrillation during the postoperative period ordinarily can be met by the administration of digitalis. This simple fact has been apprehended by those not particularly interested in cardiology, with the result that we rarely are asked to see a patient with auricular fibrillation who has not already had digitalis. In many instances, our presence is unnecessary because reversion to sinus rhythm or adequate control of the ventricular rate has been accomplished before we arrive on the scene.

In the treatment of the paroxysmal tachycardia of regular rhythm, recording of an electrocardiogram is highly desirable as the primary step, because by this course alone can the exact origin of the tachycardia be identified. If the complexes are arising from a focus in the ventricle, then quinidine and not digitalis is the medication of choice. If the tachycardia is of the supraventricular type, then either drug may be used with ap-

proximately equal chances of success. The bases for reaching a decision with respect to which of the two should be tried first never have lent themselves to precise definition, in my experience. Perhaps the most serviceable generalization has been this: when evidences of failure are present, give digitalis in preference to quinidine. Often, restoration of sinus rhythm does not occur after the administration of adequate amounts of digitalis. The problem then arises whether to give quinidine and digitalis concurrently. In rebuttal to criticism of the combined use of the two drugs, two observations may be made. First, the risk of using quinidine in combination with digitalis has not impressed us as being significantly greater than the risk of giving quinidine alone; second, the situation of the patient who in the postoperative period has a persistently rapid ventricular rate after the administration of adequate amounts of quinidine alone or digitalis alone is sufficiently critical that an appreciable pharmacologic hazard may be accepted justifiably.

During the postoperative period, quinidine frequently must be administered parenterally. The drug is now available commercially in a solution containing 0.6 gm. in 5 cc., which may be administered in appropriate amounts either intramuscularly or very slowly by vein.

At this particular time, discussion of the arrhythmias can hardly be concluded without some reference to the procaine derivatives. Extended comment on this subject has been avoided because of definite limitation in personal experience with this group of drugs. My colleagues in the field of anesthesia have used them more frequently over a very considerable period, and have expressed their favorable reaction to the results obtained on the administration of procaine amide to the anesthetized patient who is experiencing arrhythmias of ventricular origin. The broader aspects of this problem recently have been reviewed by Kayden and his associates.²

Summary statement may be undertaken to the effect that the procaine derivatives are of established usefulness in the treatment of arrhythmias of ventricular origin. Whether their administration will extend remarkably the boundaries of therapeutic efficacy defined by quinidine and digitalis remains to be determined by the test of a broader clin-

ical experience.

Shock.—The position of the physician speaking about shock in the cardiac patient undergoing surgical treatment has much in common with that assumed by the minister who assigned himself the task of preaching about sin. Our most fervid contemplations, like his, might be summed up in the phrase of the laconic Yankee: "He was agin it." Certainly there is good reason to believe that the cardiac patient in a state of shock occupies a most precarious position. Coronary insufficiency, if latent, becomes manifest and may result in acute myocardial infarction. Episodes of occlusive thrombosis, cardiac or cerebral, may be induced, and these are but accretions to the basic hazards of the shock state in the patient of normal cardiac status. Treatment certainly is more effective at the level of prevention rather than alleviation, and the measures for prevention are as broad as the scope of this entire discussion. If good judgment and good fortune have prevailed, there will be no shock. If there is shock, then treatment of it in the cardiac patient is in no way distinctive from the usual therapy for this unfortunate complication.

Comment and Summary

At this juncture I am reminded of a character in fiction who was described as having a passion for "dissecting the obvious, discovering new facets in the commonplace, and squeezing the last drop out of a foregone conclusion." If there is anything very profound or very novel to disclose about the care of the cardiac patient undergoing surgical treatment, I fear it remains to be said. Probably the main reason discussions of this order come into being is that most of us like to be sure the other fellow is no smarter than we are when it comes to handling the frustrating experiences of medical practice. Now that I have established community of suffering with the majority, let me close by restating those points which I believe to be worthy of emphasis.

First, in evaluation of cardiac reserve, no evidence is superior to the patient's own account of what he can do.

Second, beware of the patient with coronary disease whose symptoms indicate that a precarious state of imbalance exists in the nutrition of certain areas in the myocardium. Only the most imperative surgical indications

justify proceeding in the face of this strong demand for delay.

Third, acute pulmonary edema in the postoperative period is a true cardiac emergency. Digitalis administered intravenously in doses of assured adequacy is fundamental in resolution of this crisis.

Fourth, the unresolved dilemma in anti-coagulant therapy is when, in relation to the surgical procedure, it should be instituted.

Fifth, the hazards imposed by cardiac arrhythmias occurring in the postoperative period warrant assumption of the risk which attends a strong therapeutic attack with quinidine and digitalis.

REFERENCES

1. Ray, T. and LaDue, J. S.: Intravenous Administration of Lanatoside C to Patients Taking Maintenance Doses of Folia Digitalis up to Date of Hospitalization With Recurrent Congestive Heart Failure. *Am. Heart J.* **30**:335-340 (Oct.) 1945.
2. Kayden, H. J., Brodie, B. B. and Steele, J. M.: Use of Procaine Amide in Cardiac Arrhythmias. *Mod. Concepts Cardiovas. Dis.* **20**:100-101 (June) 1951.

LIVER DISEASE

(Continued from Page 243)

2. Neefe, J. R., Stokes, J., Jr., Reinhold, J. G. and Lukens, F. D. W.: Hepatitis Due to Injection of Homologous Blood Products in Human Volunteers. *J. Clin. Investigation.* **23**:836-855 (Sept.) 1944.
3. Paul, J. R., Havens, W. P., Jr., Sabin, A. B. and Philip, C. B.: Transmission Experiments in Serum Jaundice and Infectious Hepatitis. *J. A. M. A.* **128**:911-915 (July 28) 1945.
4. James, George, Korns, R. F. and Wright, A. W.: Homologous Serum Jaundice Associated With Use of Irradiated Plasma. *J. A. M. A.* **144**:228-229 (Sept. 16) 1950.
5. Crumpacker, E. L., Stauffer, M. H. and Dockerty, M. B.: Unpublished data.
6. Butt, H. R.: Evaluation of Current Tests of Hepatic Function. *Surg., Gynec. & Obst.* **91**:363-364 (Sept.) 1950.
7. Bradley, S. E.: Variations in Hepatic Blood Flow in Man During Health and Disease. *New England J. Med.* **240**:456-461 (Mar. 24) 1949.
8. Ducci, Hector: Contribution of the Laboratory to the Differential Diagnosis of Jaundice. *J. A. M. A.* **135**:694-698 (Nov. 15) 1947.
9. Miller, E. M., Dockerty, M. B., Wollaeger, E. E. and Waugh, J. M.: Carcinoma in the Region of the Papilla of Vater; a Study of Cases in Which Resection Was Performed. *Surg., Gynec. & Obst.* **92**:172-182 (Feb.) 1951.
10. Douglass, B. E. and Snell, A. M.: Portal Cirrhosis: An Analysis of 444 Cases With Notes on Modern Methods of Treatment. *Gastroenterology.* **15**:407-425 (July) 1950.
11. Patek, A. J., Jr.: Treatment of Alcoholic Cirrhosis of the Liver With High Vitamin Therapy. *Proc. Soc. Exper. Biol. & Med.* **37**:329-330 (Nov.) 1937.
12. Blakemore, A. H.: Portacaval Shunt for Portal Hypertension; Follow-up Results in Cases of Cirrhosis of the Liver. *J. A. M. A.* **145**:1335-1338 (Apr. 28) 1951.
13. Davis, W. D., Jr. and Arrowsmith, W. R.: The Effect of Repeated Bleeding in Hemochromatosis. (Abstr.) *J. Lab. & Clin. Med.* **36**:814-815, 1950.
14. Stauffer, M. H., Dornberger, G. R. and Dockerty, M. B.: Unpublished data.

EDITORIAL PAGE

ASSOCIATION MEMBERSHIP

More and more physicians are finding that "in union there is strength." As the years pass by, they, like other minority groups have accepted the "association" as an integral part of their professional life. The South Dakota State Medical Association, through its officers and employees is constantly working at the improvement of the profession. The results are obvious in the news story that appears below.

MEDICAL ASSOCIATION MEMBERSHIP SHOWS STEADY FIVE YEAR GAIN

The South Dakota State Medical Association has shown a steady gain in membership over the past five years as indicated in the statistics below:

Year	1947	1948	1949	1950	1951
Total Membership	326	360	406	424	430

Although district membership figures are not available for 1947, the increase is shown graphically over the past four years. (1951 figures are incomplete because of delinquent payments. 1951 total will undoubtedly be higher than listed.)

	1948	1949	1950	1951
Aberdeen Dist. #1	46	48	45	46
Watertown Dist. #2	24	27	30	31
Madison-Brookings Dist. #3	26	28	30	26
Pierre Dist. #4	16	19	17	24
Huron Dist. #5	20	21	23	24
Mitchell Dist. #6	31	34	31	34
Sioux Falls Dist. #7	71	96	98	101
Yankton Dist. #8	36	38	42	43
Black Hills Dist. #9	61	63	75	72
Rosebud Dist. #10	6	5	8	7
Northwest Dist. #11	8	13	9	10
Whetstone Dist. #12	15	14	16	12
Total	360	406	424	430

GULLIBLE'S TRAVELS

(All Executive-Secretaries are Gullible)

June 26 — in the midst of the monsoon

season in eastern South Dakota, I paddled my way to the Lutheran Welfare office to attend a meeting of the Board of Directors of the newly proposed mental health center for Minnehaha County.

June 29 — Met with **Dr. Jack Donahoe** and attorney **John McQuillen** at the Elks Club in Sioux Falls to discuss plans for a budget for the South Dakota Heart Association.

July 3 — Spoke to the Canton Rotary on the function of medical associations at the request of **Dr. Cloid Green** and then visited the very excellent Canton-Inwood hospital.

Spent most of rest of the week at my desk in Sioux Falls and on July 9 drove to Pierre with **Dr. L. J. Pankow** to sit in on a stock-growers conference on undulant fever. Returned to Sioux Falls on the 10th.

July 11 — **Dr. D. A. Gregory**, association president visited the office to spread his usual good cheer.

That evening, **Dr. C. J. McDonald**, chairman of the prepayment committee, **Mr. C. H. Stevenson**, secretary of the St. Paul Mercury Indemnity Company, and I met at the office for four hours in the evening discussing insurance problems.

July 16 — My wife and I left for Rapid City, I to attend the Board of Examiners meetings and wife to relax away from the youngsters.

On the 17th and 18th met with the Board, took notes and recorded it all for the permanent minutes.

Managed to see some of the Hills, saw some dogs chase a rabbit and enjoyed Rapid City's 104° temperature.

July 26 — Met with representatives of other health groups to discuss sponsorship of the "Fight for Life" radio series in Huron.

RECOMMEND THE NON - CAN
SOUTH DAKOTA INJURY - ILLNESS EXPENSE PLAN
THE PAUL REVERE PLAN

314-16 Paulton Building

LEE McCAHREN

Sioux Falls, South Dakota

This is



SEPTEMBER
1951
Vol. 4 No. 9

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

USD Medical School Cites Research Program

Medical research carried on by the staff of the School of Medicine at the University of South Dakota has brought national recognition to the school. Research projects carried on by 21 of the staff members were the subjects of 25 different articles carried in medical and other scientific journals published in this country during the past school year, a recent survey shows.

Dr. Donald Slaughter, dean of the school, lead his staff in the number of research projects and articles published concerning them. He was the author of five articles and co-author of six.

Dr. Walter Hard, assistant dean of the Medical School and chairman of the anatomy department was co-author of four articles dealing with as many research projects that he directed.

Costs of most of the medical research in the University's School of Medicine were borne by private corporations, federal agencies or voluntary medical and health organizations. State funds were used only to a limited extent, Dean Slaughter re-

ports, he said, "Without these funds from private and federal sources outside the school, medical research in South Dakota would suffer greatly and would be reduced drastically. Salaries of technical assistants, and laboratory facilities were furnished from state funds."

Research carried on by the School of Medicine staff during the past fiscal year, ending June 30, ranged from a study of synthetic analgesics ("pain killers") for humans to research on the direct and indirect effects of X-rays on enzymes. Of the 21 staff members taking part in the research work, Dean Slaughter says that only seven were graduate students. The rest were full-time staff members who carried a full load of classroom teaching in addition to the research work they found time to perform.

Funds in the form of grants for research were received from: the South Dakota State Cancer Society, Mrs. Lucille Dory, state chairman, Watertown; the South Dakota State Tuberculosis Association, Dr. I. D. Weeks, state president, Vermillion; the U. S. Public

Health Office, the Office of Naval Research, the Marine Biological Laboratory, Woods Hole, Mass.; the Physiological Chemical Co., St. Louis, Mo.; the Physicians Drug and Supply Co., Philadelphia, Pa.; Hoffmann La Roche, Inc., Nutley, N. J.; the Henry K. Wampole and Co., Philadelphia, Pa., and Carlo-Erba, Milano, Italy.

Staff members who carried on research in the School of Medicine, in addition to Dean Slaughter and Dr. Hard, included: Dr. Rubert S. Anderson, executive professor of physiology; Dr. J. B. Belagorsky, assistant professor of pharmacology; Keith Sehner, graduate assistant; Richard K. Hawkins, graduate assistant; Alvin C. Peterson, graduate assistant; Merle D. Fox, graduate assistant; Dr. Charles D. Hendley, associate professor of pharmacology; Dr. Robert H. King, assistant professor of biochemistry; Elaine Nelson, technician in biochemistry; Dr. Keatha K. Krueger, research assistant professor in biochemistry; Marilyn Preheim, U. S. Public Health fellow; Dr. Charles Schwartz, research associate professor of biochemistry; William Hanson, graduate assistant; and Robert Hazel, graduate assistant in pharmacology.

28 PHYSICIANS GET LICENSES

Twenty-eight new South Dakota physicians met with the board of Medical and Osteopathic Examiners in Rapid City July 17 and 18.

Licensed by reciprocity were: **John T. Tidd, M.D.**, Yankton; **S. W. Tuell, M.D.**, Rapid City; **John F. Leeds, M.D.**, Hot Springs; **Gordon O. Olsson, M.D.**, Rapid City; **Donald J. Peik, M.D.**, Sioux Falls; **Bernard Batt, M.D.**, Dupree; **Robert B. Bray, M.D.**, Rapid City; **John W. Gridley, M.D.**, Watertown; **John J. Jestadt, M.D.**, Lemmon; **Charles B. Mitchell, M.D.**, Sioux Falls; **John J. Feehan, M.D.**, Rapid City; and **Stephen Brzica, M.D.**, Sioux Falls.

Examinations Given

Writing the two-day examinations were **Robert Hayes, M.D.**, Winner; **Burton A. Kolp, M.D.**, Volga; **Jose M. Gacusana, M.D.**, Hot Springs; **Karl M. Forster, M.D.**, Yankton; **John S. Devick, M.D.**, Colton; **Chih-li-chu, M.D.**, Sanator; **Carl J. Bridge, M.D.**, Milwaukee; **Maynard H. Porter, M.D.**, Yankton; **Chris A. Pascuzzi, M.D.**, Sioux Falls; **Olin M. Odland, M.D.**, Brookings; **Terence B. McManus, M.D.**, Milbank; **Vernon H. Cutshall, M.D.**, Sioux Falls; **Fred M. Rich, M.D.**, Elk Point; **Mark W. Myers, D.O.**, Hudson; **Robert C. Borris, M.D.**, Parker; **Raymond W. Jensen, M.D.**, U. S. army; **George M. Lindeman, M.D.**, Binder, Okla.

Pfister Again Heads Board

The board members reelected **Faris F. Pfister, M.D.**,

Webster, president of the board; **J. H. Cheney, D.O.**, Sioux Falls, was reelected vice president, while **C. B. McVay, M.D.**, Yankton, was named secretary to succeed **C. E. Sherwood, M.D.**, Madison, who has left the state. The board also named **John C. Foster**, Sioux Falls, to be executive secretary for the coming year. Offices of the board will be in Sioux Falls.

In other business of the board, Alexandria was named an emergency medical area which will allow that community to secure a DP physician. The dates of the next examination were set for the third Tuesday and Wednesday of January in the board offices in Sioux Falls.

POLIO FOUNDATION ASK ADV. COMMITTEES

The National Foundation for Infantile Paralysis is not entirely satisfied with the current arrangement for the appointment of Medical Advisory Committees and the Medical Director has requested the Board of Trustees of the AMA to take action on the following proposal:

"That in those counties where acceptable treatment facilities are already available or may be developed in the future, the county medical society recommend to the Chapter of the National Foundation for Infantile Paralysis a panel of physicians equal to double the number of committee members to be appointed, who would be willing to serve as medical advisors to the Chapter in its medical care pro-

gram. The Chapter would then name a Medical Advisory Committee from this panel which would serve the Chapter and represent the medical profession.

"It is the function of the Medical Advisory Committee to:

"1. Establish within the treatment center procedures which will be uniformly acceptable to the attending staff for the admission, treatment and discharge of polio patients.

"2. Recommend to the Chapter standards of service for which monies may be spent by the Chapter in the event the poliomyelitis patient or his parents require financial assistance from the Chapter for the payment of services.

"3. Recommend to the Chapter equipment which is needed by the treatment center for the care of polio patients.

"4. Establish a schedule for the payment of medical fees if the physicians in the community are accepting payment from a voluntary public agency for professional services.

"5. Serve as a 'grievance committee' where there are disagreements between the Chapter and an individual physician regarding fees or other practices which may not conform to the established procedures for treatment as referred to above."

Joe Dowling, former Foundation representative in South Dakota has been transferred to Los Angeles.

MEDICAL SCHOOL NAMES STAFF

Five new appointments have been made to the resident teaching staff of the School of Medicine at the University of South Dakota. **Dr. Donald Slaughter**, dean of the school, also announced appointment of Sioux Falls, Yankton and Sioux City doctors to the clinical teaching staff.

C. D. Cox, Ph.D., is coming to the University from Pennsylvania State college to be professor and chairman of the department of microbiology and public health. He received his Ph.D. degree from the University of Illinois in 1947 and has taught in the medical college of Virginia in addition to Penn State. During the war, he was in charge of bacteriology for the China-Burma-India theater medical laboratory.

Amos C. Michael, M.D., will report to the University on December 15 to become associate professor of pathology. He has held the same position at Indiana university where he was graduated in 1932.

L. F. Michalek, M.D., is already on duty as assistant professor of pharmacology in the School of Medicine. He received his M.D. degree from the University of Washington, Seattle, Wash., and did his interne work in Ancker hospital, St. Paul, Minn. He is a graduate of the division of pharmacy at South Dakota State college and a native of Ipswich.

Adaline N. Mather, Ph.D., started at the University on

September 1 to work as assistant professor of microbiology. She has been at Southern Illinois university in the department of bacteriology.

Robert Trankle, M.A., started his work July 1 as instructor in microbiology. He received his master's degree from the University of South Dakota at the end of the regular term this year.

Warren L. Jones, M.D., Sioux Falls, has been appointed associate in clinical physiology; **Robert Monk, M.D.**, Yankton, has been appointed instructor in clinical anatomy, and **Fred Stark, M.D.**, Sioux City, Ia., has been appointed clinical assistant professor of neurology and psychiatry.

POSTGRADUATE COURSE SET FOR NEW YORK

The Annual Postgraduate Course in Diseases of the Chest sponsored by the Council on Postgraduate Medical Education and the New York State Chapter of the American College of Chest Physicians, will be presented at the Hotel New Yorker, New York City, November 12 - 17, 1951.

This course will emphasize the recent advancements in the diagnosis and treatment of chest diseases. The course is open to all physicians, but the number of registrants will be limited. Tuition fee is \$50.00; applications will be accepted in the order in which they are received. Applications should be sent to the American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

ARMOUR COMPANY STARTS NEW PLANT

Ground was broken for the new Armour Pharmaceutical Center in Kankakee County, Illinois, June 21, and it was revealed that the Company hopes to begin operations there within 18 months.

The plant is being built on a mile-long, 175-acre tract just north of Bradley, Ill. The initial construction will consist of 11 buildings of modern design.

F. W. Specht, president of Armour and Company, and T. E. Hicks, vice-president in charge of The Armour Laboratories, officiated at the ground-breaking ceremonies. They pointed out that The Armour Laboratories have outgrown their present manufacturing facilities in Chicago, and that the increased demand for Acthar, insulin and other pharmaceuticals has made it necessary to set up new manufacturing facilities as soon as possible.

NEWS NOTES

Dr. and Mrs. A. H. Christensen of Clark were honored by their community at a reception at the high school auditorium for many years of service to the community. Dr. Christensen has been in practice for 53 years, most of that time in Clark.

Dr. Maynard Porter has located in Yankton in association with **Drs. Hubner, Auld and Johnson** in the field of general practice.

John S. Devick, M.D. has started practice in Colton associating with **Dr. Dehli**.

CHEST PHYSICIANS OFFER AWARD

The Board of Regents of the American College of Chest Physicians offers a cash prize award of two hundred fifty dollars (\$250.) to be given annually for the best original contribution, preferably by a young investigator, on any phase relating to chest disease.

The prize is open to contestants of other countries as well as those residing in the United States. The winning contribution will be selected by a board of impartial judges and the award, together with a certificate of merit, will be made at the forthcoming annual meeting of the College. Second and third prize certificates will also be awarded.

All manuscripts submitted become the property of the American College of Chest Physicians and will be referred to the Editorial Board of the College journal, "Diseases of the Chest," for consideration. The College reserves the right to invite the winner to present his contribution at the annual meeting. Contestants are advised to study the format of "Diseases of the Chest" as to length, form and arrangement of illustrations, to guide them in the preparation of the manuscript.

The following conditions must be observed:

(1) Five copies of the manuscript, typewritten in English, should be submitted to the executive office, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois,

not later than April 1, 1952.

(2) The only means of identification of the author or authors shall be a motto or other device on the title page, and a sealed envelope bearing the same motto on the outside, enclosing the name of the author or authors.

FSA TO SURVEY SOUTH AMERICAN HEALTH PROBLEMS

Appointment of Dr. Wilton L. Halverson of California to head a special joint survey to evaluate the health and sanitation program of 17 Central and South American countries was announced by Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, Federal Security Agency, and Kenneth R. Iverson, President of the Institute of Inter-American Affairs.

Dr. Halvorson has been given a six-months leave of absence by Governor Earl Warren from his position as Director of Public Health of the California State Health Department to head the survey, which is being carried on under the supervision of the Public Health Service. His appointment to the Regular Corps of the Public Health Service in the permanent grade of Medical Director was approved by the Senate last week.

The major purpose of the survey is to appraise the influence of the IIAA's nine-year health and sanitation program on the development of local health organizations, the rate at which the programs and methods are being incorporated into the perm-

anent health structure, and the extent to which the health habits of the people are being influenced.

The survey will be conducted under the direction of Assistant Surgeon General Joseph Mountin, Associate Director of the Bureau of State Services, Public Health Service, and Dr. H. van Zile Hyde, Director of the Health and Sanitation Division of the Institute of Inter-American Affairs. Responsibility for staffing and administering the survey is being carried out by the Public Health Service, with the funds allotted by the Institute of Inter-American Affairs.

FREDERICK C. DeVALL, M.D.

Dr. Frederick C. DeVall, aged 72, passed away at a Sioux Falls hospital August 14. Dr. DeVall was born at Le Mars, Iowa where he attended grade and high school. He graduated from the medical school at Iowa University in 1905 and soon thereafter moved to Garretson.

In 1916 he built the hospital which he had maintained until his death.

Just prior to his death, he had been honored at a mammoth community celebration with many of the "babies," now grown to adulthood, whom he had helped into the world.

Dr. DeVall is survived by his wife, a daughter, and two brothers.

NEWS NOTES

Dr. John F. Leeds, is now practicing pediatrics with the Bulter Clinic in Hot Springs.

PRESIDENT'S PAGE

D. A. Gregory, M.D.

SEPTEMBER MESSAGE



September marks the opening of the schools and our attention turns to those medical students who leave South Dakota and enter the final half of their medical course elsewhere. We hope that they will remember their preceptors.

I think the preceptor system is a fine idea and Don Slaughter did a good job when he initiated it in South Dakota. In our two year school, young medical students have had excellent training under this system. They need have no fears about maintaining their work and standards in the new schools to which they are transferred. I have talked to many of them and find that they do well, since they have had good basic training and have learned much; not only of the science of medicine, but of the art of medicine as well.

Some of our medical schools abhor the art of medicine, holding that only the science is of value. Each has its function and neither art nor science is supreme. They are complementary.

For all his eccentricities, Paracelsus way back in the fifteenth century perceived the interrelation of the art and science of healing as did none of his contemporaries, and as too few of us do today. His theory that one should look at the patient not at the book; that "reading never made a physician" seemed to his colleagues very extreme. Yet it has a point not to be overlooked. Medical science has advanced through the keen observation and individual consideration of the patient coupled with the available scientific knowledge. The body of that knowledge has increased in proportion to the development of the art of medicine: the discernment that goes beyond and supplements technical skill.

The ideas of Paracelsus make fascinating reading and re-action is inevitable — pro or con. Have you ever poked around in his past? Try it for fun and stimulating thought.

Speaking of the art of healing, I have recently had an interesting experience (in the hospital) which has sharpened my consciousness of the value of good nursing. We doctors all recognize the importance of the nurse's contribution to medical skills, but when we are patients ourselves we become more than ever aware of their contribution to the patient's morale. Those gals are a tower of strength in a time of trouble. The little personal services and the steadying presence of a good nurse are medicine that can hardly be overestimated. Doctors and nurses working with equal interest and sure medical knowledge sometimes achieve what appear to be miracles. It is the quality and spirit of the service that helps turn the tide in time of crisis. I hope that our young men will keep this in mind as they prepare for their profession and that they will remember that their medical education is just commencing. It should be a continuous life-long process. A good doctor never gets done studying his books or human nature.

September also marks the end of summer vacations. The regular medical meetings will begin soon and the interim council meeting will be held in the near future. Each district councillor should be instructed by his district as to the changes desired.

The districts societies are our basic units of organization. The better they are the better the state society will be. The meetings are beginning in the districts and there is the place to speak your piece and do your do. Please have pity on the poor secretary and help him out. He is not an animal trainer, so take your own part willingly.

Have you helped the South Dakota Endowment Fund yet?

PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor

“Modern Merchandising”

by W. L. Mickelson
Walgreen Agency Division

In semi-self service, I have never seen a subject, or heard of a subject with the terrific amount of variance of opinion as to just what the semi-self service actually is. I was in a store in western Illinois a month ago which had recently been made into a semi-self service store. This individual had spent a lot of money and had not gained any of the things he had hoped to gain. He did have merchandise, but the general layout of his store was not right because he had adopted too many certain fixtures, certain things from the self-service, and had lost sight of the fact that he could not do that volume of business in his size town, a town of about six thousand people. In semi-self service, there are a few things that should be kept in mind. In too many of these stores the aisles are not kept clear. They are cluttered so you cannot get your traffic to circulate fast enough. We use, in laying out our stores, a very minimum aisle of four and one half feet, a five or six feet aisle preferred. Another thing that many make mistakes on in setting up semi-self service is in the shelving. In many stores they are using a five to eight foot shelving, and are using it without pilaster — which are the uprights which divide the sections. They use this type of shelving because it is free of all obstruction of merchandise when you look down the side of the store. In the second place they use the low shelving so any party shopping in that store can reach the merchandise. However, when you go into that type of shelving in your store, you have gone into self-service. You are better off to use your conventional shelving, and by all means do not eliminate your cosmetic cases, your wrapping counter — and that should be a long wrapping counter, eighteen, twenty, twenty-two feet long. In the old days when we had

the short four to six feet wrapping counter, we failed to realize that the wrapping counter was the focal point in the drug store for selling. Practically every customer you wait on will follow you to the wrapping counter, consequently it should be a fixture properly displayed with a good variety of impulse type merchandise, the items that are easily forgotten. Your tobacco department, unlike the opinion of many, is one of the most important departments in your store. It creates more traffic than most any other department if you run a good department with a complete stock, sufficient variety, and a quantity of novelties and other impulse items that go there.

In regards to a fountain in your store. There is considerable discussion and differences of opinion on the need of a fountain. In our opinion, there is a need for a good fountain, but I do not believe there is one in ten stores that has a fountain shiny enough, good enough, so it will create the traffic it should. In most of our larger stores where they do a big volume of business, the fountain will produce in the neighborhood of twenty-five percent of the volume of that store. I might give you an example of what fountain traffic can do in a store. In Phoenix, Arizona, we had the fountain closed to install a new fountain. We were remodeling the store. When we closed the fountain, certain Union trouble came up and the fountain was closed for six months. Previous to this time the store was doing forty thousand dollars a month, plus the fountain business which was about twenty-five percent of the total volume. During the six months that this fountain was closed that volume didn't drop twenty-five percent, it dropped down to ten thousand a month, which was a drop of 75 percent be-

cause of the lack of traffic. Fountains do have a definite place in the drug store, and if you have a fountain, run a good fountain. Last year we did a million, two hundred thousand dollars in company stores and on twelve promotions. Promotions on such items as a banana split, fresh strawberry Sundae, etc., the simpler things. However, the promotions were backed up with banners—both for the window and the back bar, and with little menu clip-ons, a folded card which can be clipped over the menu and set easel like on the counter or pinned on the girls' uniforms. By merchandising a fountain, you can create a lot of extra business. Another thing about a soda fountain, which we think little about until we have occasion to see it. There was a time when I first started this business that a fountain was merely a soda fountain, and undoubtedly that is the belief of a lot of you men—you don't wish to monkey around with anything else. I want to tell you something that you might think about. As long as you are paying that girl behind the fountain, have a sandwich, a little salad, doughnuts and cookies, and by all means coffee. Last year out of many millions of dollars of fountain business that we did, twenty-two percent of that was on coffee alone. Coffee is the largest single beverage in the United States. If I am employing a girl to work at the fountain for me, I don't care much whether she is drawing an ice-cream soda, coffee, or what it is, just so she is keeping busy and building as much volume as possible during her working hours. Watch your pricing on menus. Don't lose money, you can't lose money. If you can't get a fifty-five percent gross on your fountain and more in some areas, you certainly are not going to make any money on that soda fountain. Here is why I say in certain areas. In San Francisco, the scale for a fountain girl is one dollar and fifty-six cents an hour. Think, that is two and one half cents a minute. If it takes her a minute to walk to a booth and a minute to walk back, you have a nickle. You have to have a good profit on your soda fountain operation. On the other hand you can go to St. Louis, which is a lower price town, quite free from the same type of Union type set up that we have on the west coast. Here the fountain girl gets sixty-seven and one half cents an hour. That is why you pay forty to forty-five cents for

a ham sandwich, forty cents for a malted milk, in comparison of twenty-five to thirty cents in your central states. Your fountain can produce traffic if it is run right, but you cannot run it right by having an old type fountain, probably without stools, with warm carbonated water, and soiled glasses on the back bar which should be used for display. If you do not want a fountain, you must step up your advertising and your promotions in your store in order to increase the traffic. Here is something else about a fountain. If a person wants a package of razor blades, it is an easy item to forget, anybody can pick up that package of razor blades. If you want to buy a sandwich, it brings you into that store yourself. I just mention these things as little thoughts about soda fountains, but, by all means, if you are going to have a soda fountain, have a good one. Another thing I would like to mention—get rid of the booths—with the high price of merchandise and labor you have at that fountain.

Here is probably the one thing you can take from a semi-self service store that has come into the modern drug store installation—that is the gondola type display. This type of display was put on the market a couple of years ago by J & J. This display is the proper height, it has adjustable shelves, they are divided in the center. On this display, put a sign "Service yourself and pay at the wrapping counter." This encourages self service. You will get out more merchandise and more variety of merchandise.

In laying out a store. I know a good many druggists who have remodeled their stores have gone to fixture companies for their basic lay-outs. I do not believe there is a fixture company, at least very few, who can lay out a drug store for you. I do not believe this is where you should go. You are going to spend a lot of money and spend a lot of it foolishly if you do. I think the lay-out should be finished first, finished from the angle of a druggist, and the angle of a good retail druggist; and with the idea that it will do the job that you want done in your store. I was in a store in Grand Union, Michigan, two weeks ago. This man had just spent fifty-seven hundred dollars. A fixture company in that area had drawn up a fancy plan, cut a hole in the wall, put in a prescription department, circular shape, with sufficient counter space for six

pharmacists to work. Yet he only fills fourteen prescriptions a day. By doing this they had not only spent fifty-seven hundred dollars of his money, plus the removal of that section of wall, they robbed him of quite a good size wall space that he needed so badly in that store. Remember their job is to sell fixtures. After you get a plan drawn with proper designed fixtures, then these companies can come in and build the fixtures for you, but there are too many mistakes being made all around with bottle-necks. When you remodel a store, you should sit down and analyze your business. The number of prescriptions you fill will somewhat determine the size of your prescription department. If you fill one hundred prescriptions a day, you certainly are going to need a larger prescription department than if you filled only fifteen or twenty a day. Some stores go into Veterinary products, consequently need a larger veterinary department. Some stores carry costume jewelry, which is a good gross profit line, and need a larger costume jewelry department, or case provided for same. Some stores will have twenty-five or thirty feet of cosmetics, while another will have five or ten. All the way through that store you should analyze and plan that lay-out to fit the type of business you are doing. All this should be done before you start fixturing that drug store. Today prices are high, there is no question about it, and many men do not feel they can afford a complete fixture lay-out. I would say that in seventy-five percent of the cases, it is not necessary. The main thing to take into consideration is your floor, merchandising area of your drug store. Get your floor plan right — from your cigar department right back to the prescription department; and by all means get your display units in the center of the floor. That is where you get into your terrific amount of impulse buying. If you cannot afford a complete new lay-out, there is one thing you can do to gain — to a very large degree — the same affect and similar appearance. You can mix old fixtures with new, and refinish your wall shelving by using an enamel instead of using costly new wood. If you will enamel your old fixtures and add the new in that same color, you will arrive at the same over-all appearance in your store. When you are doing that, by all means, use light colors. Do not go into dark

colors. When you do that, probably floor covering and lighting are the two most important extras that you can put into that store. I have never walked into a store where they had a wood floor, even though the fixtures might be new, that did not have an old or junky appearance. Cover the floor with something, whether its lineoleum, asphalt tile, or whatever it may be, but do have a floor covering and keep it clean.

Lighting is the most important thing in your store. Have plenty of it. The belief on the part of many men is that lighting is for night hours. Truthfully, your lighting is more important during the day time. If you pass a syndicate store, you will note that the lights are always on. In Minneapolis, take Kresge's, the windows are all around the store yet every light in the store is on every day. The reason for this is when you come into any store from outside, the light by contrast to the inside of the store, for at least a time until your eyes adjust themselves, you have difficulty seeing the merchandise and the things the druggist wants you to see when you come into that store. On the other hand, when it is dark outside, if you put a hundred watt bulb in your store, it would be light by contrast to the darkness outside. Don't depend on window light for your day time lighting. Have your lighting where it will show on the merchandise. The lighting we have adopted today is General Electric slim line lighting. We have adopted it for two reasons. Slim line lighting has two things that fluorescent does not have. In the first place it does not have a glare, yet it has a terrific volume of light. When you walk into that store you are not conscious of the light, yet it is there and you see everything perfectly. In the second place, it has a penetration that fluorescent lighting does not have. If you place fluorescent lighting at the height that lighting should be placed in a store, by the time that light reaches the merchandise, it has lost a big percentage of the light that it should have on the merchandise. For case or display lighting, that is another thing, fluorescent does a good job here.

Another thing that has been discussed a great deal is store fronts. The cry has been to get rid of those display windows. That was probably one of the biggest mistakes made in the outside appearance of a drug store from

the standpoint of what it will do for you. Today, there is a terrific movement from one end of the country to the other, and particularly on the west coast, to eliminate the visual fronts, not by changing that front probably, but by putting display windows in at least part of it. You can put in display windows without stopping the visual benefits from that front. You can put them on either side. After all, they can cover up the isles, which is probably the part of the store you do not wish to show anyway. To show you what a window display will do for you. In Oregon, two years ago, a man spent fifty thousand dollars on a store he had bought, and among other things had a complete visual front. He bought a gross of piggy banks. In four weeks he sold nineteen of them with a good display, but that was not enough movement. He then decided to put a table up to this beautiful visual front and placed about three dozen piggy banks on that table. At the end of another six weeks, everyone was gone. You need your windows, gentlemen, to introduce new items, for seasonal merchandise, for variety merchandise; and it makes it look more like a drug store. I do not think you should have complete one hundred percent visual fronts because you can get vision along with the benefit of display windows.

When you remodel your store, it is not just a process of changing fixtures and a few other things. When you remodel a store today and spend that money, I think you should give a little thought to remodeling along with the fixtures if that store is going to get that extra momentum that it should have. After the store has been remodeled, or partially remodeled, there is one thing that can be the most important three days in the history of that store from that point on, and it will carry over for a long, long time. That is the way you introduce that store to the public. In other words, your Grand Opening, and by all means have one. It isn't too difficult to get a newspaper to work up an entire section, they welcome an opportunity to sell advertising — pictures of the store, pictures of the employees, congratulatory ads, etc. This along with your circulars, radio spots, (if you have a radio station) plus certain door prizes. When you select door prizes, small ones are all right and you should have them, but have one key prize, something people want as a

washing machine, electric stove, or some electric appliance. If you don't think that pulls at an opening, I can name you towns not too far from here, in this Dakota area. We had an opening about three and one half years ago in a drug store in North Dakota. This druggist had remodeled his store and increased his space to a thirty foot front. The day of the drawing, which was on Saturday, there was a freezing drizzle and about one half inch of ice over everything. It was a miserable day, yet we had forty-five hundred people, or almost the equivalent of the population of the town, gathered in the street in front of that drug store when this drawing took place. That grand opening can give you an immediate increase in volume, figures that you probably will not believe, but the very minimum in most cases of twenty-seven, twenty-eight, on up to two hundred or three hundred percent. You gain something there in a two or three day period, that if you wait for just the natural trend of events to bring it about it might take you a year or two years to accomplish.

This visit so far probably has not been dealing with some of the basic things on merchandising, although they are all parts of merchandising. If you were asked the meaning of merchandising, I question if you could give an intelligent definition. Merchandising is a combination of many things done right and done continually. This is not a periodic job. It is something that must be kept up. Merchandising has two areas of operation, one is outside of your store and the other is the interior of your store. You can have the best drug store in the world, the most beautiful fixtures, manned by the most intelligent and courteous salespeople, complete merchandising inside, but if no one walks into that drug store, you are not going to do any business — so let's think about the outside, which is also a part of this over-all picture on merchandising. In the first place, let us talk about your windows. In any town, practically everyone that lives there at some time or another passes your windows. Your windows may be one of the things that brings that person into your store if you display them well. I don't mean a lot of bill boards on some particular cigarette or appliance, but I mean some well merchandised display windows. They will pay off and they should be

kept up. Use proper signs. Write them up so they will be interesting. People are natural born window shoppers. In the second place, your newspaper advertising comes into this outside sphere, your circulars, radio, road signs — all of these are very good advertising if you use enough of them, but don't think in terms of one or two or three, it won't do you any good. Another thing that is important is your outside identification. Do spend some money and get a good Neon sign. Get one that tells the story of whose drug store it is, have your own name and the name of your store predominate in size over any other name. Don't let the soda or ice-cream company's name, or cola name, appear on that sign. Let people know the name of your store and who you are.

The other sphere of your merchandising is the inside of your store, your store lay-out which we discussed a minute ago. Do not have a cluttered up arrangement. The size of your store will determine the variety and selection of merchandise you can put in that store. When you put it in, departmentize it, group merchandise of a like type so people can find the merchandise. Today other people are invading the drug store in no small degree. In order to make your store a more interesting store, a better store for people to shop, with a lot more impulse sales, a better gross profit, put a variety of merchandise in your store. In displaying this merchandise, in addition to putting catch signs up, price your merchandise. That is one of the biggest mistakes you can make in putting in a display, to fail to price ticket that merchandise.

Merchandising is a full time job. It is not a job that can be done in a day and then wait a couple of weeks and to it again, then wait a couple weeks more and do it again. When you get your store set up, you are going to hold a better peak volume through the months and years if you will make it a point in your store to keep that store displayed completely every day. There are a few ideas that I would like to pass on to you in gaining this. You can hire the best drug clerk in the world and put him in your store, but unless you as the owner or manager of that store are willing and able to have enthusiasm and spark-plug your own organization, that same clerk is going to think, "Well, what's the use." After a month or two after he has lost some

of his enthusiasm, he is going to come down to the level that you set. They are not going to do anymore than they have to for their money as a rule, so you should spark your own organization with enthusiasm and doing the right kind of a job yourself. Another thing that is very important is to keep your displays up, take a look at every department in your store every day. Be sure that the displays are right, see that things are clean, see if each department is doing the job it should be doing for you to get the most business out of it. One way to do this is to take notes as you go over your different departments. When this is done, delegate the responsibility of getting things as you want them. Some people don't know, they have to be told. Take the average girl in a store. If you show her or tell her what you expect to be done, and what you want to be done, and you show her two or three days in a row, you are not going to have to show her too long. Your help is going to be keeping that store up during the day — you aren't going to have to continue taking these notes. However, I can't stress too strongly the importance of your surveying your store each morning. It will pay off. Have your store set up so it will be an interesting place to shop, arranged in such a way that it will catch the eye.

You can promote enthusiasm in your store in a great many ways. A few of these are: friendly competition in sales, P. M. system, incentive system. Store meetings is another means of promoting enthusiasm. Very few stores conduct good store meetings. The number of clerks does not matter. You can select an hour in the day when it is rather quiet and take at least part of your force to the back room or basement and spend ten minutes in introducing new merchandise that has come into the store. Tell them about it, introduce new items, tell them of plans that you have in mind. After all, one of the first laws of selling is to know your merchandise and being conscious of your merchandise. Know your merchandise yourself and pass it on to your help.

One of the most important departments in your store today, and perhaps the one that is most frequently neglected, is your Vitamin department. Vitamins represent twenty-two percent of the total drug and proprietary sales in the United States, cosmetics represent

eleven percent, yet you can walk into many stores and find ten or twenty feet of cosmetics, with an investment running into many thousand dollars, yet probably the Vitamin department is on the wall shelf. If so, they will stay on the wall shelf unless you get them out, it is good volume and profitable volume. The average sale on over the counter vitamin is not a thirty-three and one third percent or a twenty-eight percent item. If you are not running a good Vitamin department, you are passing up some good profitable volume.

Today, and for the last several years, we have been experiencing a trend which is serious as far as our business is concerned. There has been a gradual lowering of average gross profit in the drug store. Even during the depression, the days of competitive operation and before Fair Trade came in, we were able to maintain in the City of Chicago an average of 36.4 percent. Today, we can't do that. Your gross has been going down and your overhead has been going up, and only because you have had in the last few years a volume far in excess of what you enjoyed before the last war, have you been able to come out with a net profit at all. I saw a survey this week on the trend of gross profits in the drug business since January 1. The first five months of this year by comparison with the same five months a year ago, shows a drop of one and six tenths percent in gross profits — so the trend hasn't stopped. This covered one thousand, six hundred and fifty six drug stores. As long as that is true, if you take the path of least resistance and run a drug store just for people to come in and ask for a certain item, take care of their specific call, you are not doing anything to correct that situation in your store. I think today, more than anytime in the history of our business, we should give more thought to some of the departments that pay us more than a living profit. Among those would be your Greeting Card Department, which is a fifty gross department, and your Costume Jewelry Department. All through the store you can pick departments which give you better than gross volume. In your thinking, remain willing to at least look at what is on the other side of the fence to see what is going on. We have to continue to think aggressively, be willing and able to make certain changes and

keep up with the times. If you will have that determination, you will be the leading druggist in your community in spite of anything. Believe it yourself, believe in yourselves, spark your organization, get your store right, brighten it up, and do some advertising. If you make up your mind you are going to do the right kind of a job, you can. There is no question about it. Remember this, you don't have to double your volume, you can double your net profit. This is a good business, it is interesting, it can be profitable.

Now, the things I have told you are either right or wrong, they are good or bad, but it can't be both, it is impossible. If they are right and if they are good, give them some serious thought. Try and do a few of these things in your own store.

COMMUNITY PARTICIPATION IN PSYCHIATRIC NURSING

Katherine MacMillan, Secretary, Committee on Psychiatric Nursing. Harold Tischer, Member Advisory Committee.

Monday, July 2 the State Advisory Committee on Psychiatric Nursing met at the Yankton State Hospital. On this committee are both professional and lay people. Citizen participation is essential to the proper direction, development and extension of every health and welfare service in every community. It is essential because these services belong to the people. It is essential because a profession grows stale unless it is constantly ventilated by the fresh air of citizen inquiry, criticism and cooperation.

The Committee on Psychiatric Nursing is interested in the entire program of nursing education, but especially as it relates to the mental aspect of illness, the promotion of mental health and the prevention of mental illness.

One immediate objective is to set up an affiliate school in psychiatric nursing at the State Hospital. The students from the schools of nursing in South Dakota would be sent to the State Hospital for three months clinical experience in psychiatric nursing. Almost all states require such an affiliation now, South Dakota included. It is generally concluded that even three months is insufficient time to give student nurses a thorough introduction to psychiatric nursing. However it is

the required minimum for approval by the American Psychiatric Association. The job ahead is to set up the three months course so that it provides an educational experience to the affiliate nurse. The South Dakota legislature has appropriated money to get started with the program. There is much planning and work to be done before the situation would provide a suitable learning experience for students. It is with this over-all planning that the Committee on Psychiatric Nursing is concerned.

Not so long ago the psychiatric nurse was almost unheard of. What has helped the psychiatric nurse to become a person with a real desire to give care to the mentally ill? Our changing philosophy of nursing education has stressed the need for complete physical and mental care of patients.

The picture of psychiatric nursing is still far from good. State mental hospitals are desperate for well trained personnel including nurses. In a survey made in 1950 by the American Psychiatric Association the findings showed a ratio of one professional nurse to 823 patients at the South Dakota State Hospital. At that time there were only two states in the union where the ratio of nurses to patients was lower than South Dakota. As of July, 1951, the ratio of professional nurses to patients is one nurse to 280 patients. On the basis of the 1950 survey this ratio would place South Dakota 38th on the list in regard to professional nurse-patient ratio.

Many people are confused as to what a psychiatric nurse does. What does she do? They ask. The psychiatric nurse is a member of a team — the psychiatric team. The psychiatrist, clinical psychologist, psychiatric social worker, the psychiatric nurse, occupational and recreational therapists, and the attendants or psychiatric aides make their greatest contribution to the conquest of mental illness when they work in close partnership with each other.

With the exception of the attendant the nurse spends the most time with the patient and is the one who has most opportunities to observe the patient's behavior and win his confidence. Ultimately all objectives of nursing care are determined by the needs of the specific patient but this does not obscure the fact that there are basic principles in the field of psychiatric nursing. In varying the

plan for care from type to type of behavior, from patient to patient, there is a difference that is not one of kind but rather a difference of emphasis. Reason and logic underlie the principles of psychiatric nursing and the nurse needs to recognize the similarity of problems presented by the patients as well as the differences.

We hear much today about the psychiatrist as the "father" figure. Let us think of the nurse as the "mother" figure. Her daily work consists of absorbing details and routine, manipulating the environment both for the psychiatrist and the patient to cushion unavoidable irritations, delays and misunderstandings. She must be capable of earning the confidence of both patients and personnel. She must be aware of the capacity of the individuals who work on her ward and delegate proportional responsibility so that she will have more time to spend with those in her care. She must be able to interpret her own observations skillfully and all that is reported to her by others. The psychiatric nurse must accept with no barriers all deviant behavior as symptomatology and treat it under the direct order of the psychiatrist.

A prior and fundamental responsibility rests with the members of the nursing profession on the Advisory Committee. They must do what no one else can do for them. They must set the standards for nursing care of the mentally ill patients and maintain them beyond reproach.

The participation of citizens is essential in this whole process of bringing about improvements in the nursing care of mentally ill patients and the setting up of an affiliate school. Psychiatric nursing is one aspect of a community health service. The purpose of health services is to prevent breakdowns or disintegration in the lives of human beings, to conserve life and enrich human relations. When the citizen and nurse each play his part, a team is created that can be increasingly effective in reaching its objective.

NEWS ITEMS

President A. O. Bittner of Aberdeen and Vice-President J. C. Shirley of Brookings will be delegates from the South Dakota Pharmaceutical Association to the N. A. R. D. Convention which meets in Minneapolis. October 14 to 18.

Larry Sendelbach (S. D. 1950) in partnership with **Ted Anderson** is opening a new store at Pipestone, Minn.

* * * *

Pharmacist **B. C. Christianson** has opened up a new pharmacy at Corsica under the name Christianson Drug. Corsica has been without a registered pharmacy since the Den Desetes moved their drug store to Mitchell two years ago. Mr. Christianson formerly operated a drug store in Sioux Falls.

* * * *

Pharmacist **Harold B. Lambert** purchased the drug store at Alpena from John Benson who is now retired. Mr. Lambert will operate under the name **HAROLD'S DRUG STORE**.

* * * *

When the Board of Pharmacy met in Rapid City on June 26, they approved and accepted the reciprocal application of **Clarke E. Engle**, Ph.G. for license by reciprocity from the State of Pennsylvania. Mr. Engle owned a drug store at Chadron, Nebr. from 1937 to 1948. He purchased the former drug store at Hill City and now operates it as the Hill City Drug.

* * * *

T. J. Lally, 70, Montrose, S. D. died on July 19th. He formerly operated a store at Montrose and was a pharmacist in good standing at the time of his death although not actively engaged in the profession for some time.

N. A. R. D. CONVENTION

The annual convention of the N. A. R. D. Convention will be held at Minneapolis on Oct. 14 to 18th. Here is the chance you have been waiting for to attend the convention without travelling thousands of miles to do so. The committees have arranged a wonderful program of business and professional speakers as well as an entertainment program that includes stars of radio, screen and stage and the Minneapolis Symphony Orchestra.

In addition to the many prizes offered by Exhibitors there is the Grand Prize of a 1951 Studebaker Commander and 20 Zenith Portable Radios, as attendance prizes. If you have not already made your hotel reservations, do so at once. You can also register in advance for the convention, by writing Bliss Wilson or the Twin City Retail Druggists Association, 1951 University Ave., St. Paul, Minn.



From where I sit. by Joe Marsh

What's So Funny?

Just finished reading a magazine article that "proves" you and I don't know what's funny.

Some psychologists came to this sad conclusion after telling jokes to a group of college students. Very often they would give out with what they considered a side-splitter—and not get even a chuckle. Other times the students would laugh their heads off at stories that weren't considered really funny.

From where I sit, I fail to see what makes a psychologist a better judge of humor than the rest of us. If a man gets a kick out of a joke that proves it was funny to him—doesn't it?

When psychologists try to set up a standard for a sense of humor for people they're getting too darn serious for me. It's the same thing when other "authorities" try to tell a man how he should practice his profession, or what kind of beverage he can drink. I'm partial to a glass of beer with meals myself—but I promise not to make any wisecracks if you prefer tea.

Joe Marsh

AUXILIARY ACTIVITIES

WOMAN'S AUXILIARY

Dear Members:

This is my first message to you, as your president of the Woman's Auxiliary to the South Dakota Medical Association, and I wish to extend to each of you sincere and warm personal greetings and to thank you for the privilege of serving in this capacity. I will try my best to carry on the work which has been started and to enlarge our field to better serve the profession.

Since the convention, I have been getting reports in to the Central office in Chicago. Names of the state officers and committee chairmen have been sent in as well as many of the district chairmen. All this is necessary so that these people may receive material relative to their departments just as soon as it is approved by the Advisory Council, and plans can be made for the year's work. Let us make use of a part of this material, at least, for each of us can benefit from it. A few minutes per meeting, given over to the various chairmen, will furnish material for a discussion from which we can not help but gain.

Let us consider for a moment the over-all picture of the growth of the Woman's Auxiliary to the American Medical Association. From a small group, organized on a purely social basis in 1922, it now numbers 57,547 doctor's wives. During the past two years, the American Medical Association has been thankful for the help, received from the Auxiliary, in securing "Grass Roots" support from other organizations, in its stand against socialized medicine. Dr. John W. Cline, President of the A.M.A. warns us that "it is important that this work be continued."

This year, at the Atlantic City convention, the Woman's Auxiliary to the American Medical Association made the following contributions:

To the American Medical Education	
Foundation	\$10,000
To the World Medical Association	100
To the Committee on Careers in	
Nursing	500

This is a total of \$10,600, which is a substantial amount, and the causes of each are worthy. You, every member of the Woman's Auxiliary to the South Dakota Medical Association, had a part in the making of these contributions. A part of each member's dues are sent into the Central office and it is this way that such gifts as those stated above, are made possible. Let us keep pace with this growth and have every doctor's wife a member of the Woman's Auxiliary to the South Dakota Medical Association.

We are planning to get four Newsletters out to Auxiliary members this year. So many expressed their approval of these at convention and felt this was one way to keep informed of what was being done by our group. Mrs. A. P. Reding has consented to serve as editor for this year, and she urges each district to send her news each month. Won't you have your public relations chairman do this? We hope to get the first Newsletter out in early September and this will contain a few instructions for presidents and chairmen. Let us begin our work in earnest and make this year a profitable year for all of us in Auxiliary. Mrs. Howard R. Wold, Pres.

Woman's Auxiliary to the
S. D. Medical Association.

WOMAN'S AUXILIARY

At the convention in Aberdeen, we were very happy to meet honorary members whose interests are still with the Auxiliary work. We are asking each president of each district to send us the names and addresses of their honorary members so we can add their names to the mailing list of the Newsletter. Won't you do this at once and send these names to me?

A list of National Auxiliary chairmen will soon go out to district chairmen. Contact your department chairman for material for the districts if you do not receive it by Sept. 15. Thank you so much.

**Doctor . . . why not take your Journal home
so your wife may read this page?**

Hematuria*

C. D. Creevy, M.D.
Minneapolis, Minnesota

Hematuria per se means no more diagnostically than a solution of the continuity of the lining mucous membrane of the urinary tract somewhere between the upper pole of the kidney and the external urethral sphincter. When it is unaccompanied by other phenomena, it tells us no more than this about its source nor about the nature of the causative lesion.

The Origin of Hematuria
(2,400 Cases)

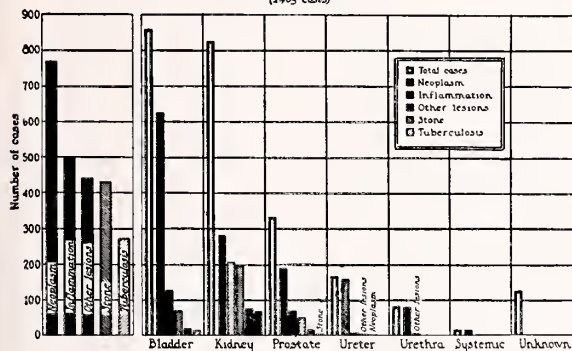


Fig. 1

Figure one serves only to give us a rough clue as to the origin of the hematuria both according to the organs and according to the type of disease in a series of 2,400 cases collected from the literature.

The history is as likely to be misleading as to be helpful for reasons pointed out below. We may make a few rough generalizations which are no more than suggestive. For example, when blood mixed with the urine is the only complaint, a tumor of the bladder is the most probable but by no means the only possible diagnosis. When gross hematuria is accompanied by renal pain, the combination suggests a renal neoplasm. When the hematuria is scanty and accompanied by renal colic, it suggests a stone in the renal pelvis or ureter, but may be due to a neoplasm, the

colic resulting from the passage of small clots. When there is a prolonged history of antecedent vesical irritation, tuberculosis naturally comes into question, and when there is a history of obstruction to urination which antedates the hematuria, one thinks naturally of the prostate, although this is not by and large a common source of bleeding.

The value of the history is impaired by the fact that blood having its origin in the kidney may clot in the bladder and cause vesical irritation or even urinary retention and lead the physician to focus his attention wrongly upon the bladder.

Similarly the physical examination is often not helpful. A neoplasm of the kidney must be of fair size and in the lower pole in an individual of average build in order to be palpable. In the robust or fat individual, even a large neoplasm may escape careful examination. Carcinoma of the renal pelvis may go on to a fatal termination without producing palpable enlargement of the kidney even in a thin individual. Moreover it is often difficult on simple physical examination to differentiate between a neoplasm, a cyst, a large hydronephrosis, and a pyonephrosis. Consequently, the absence of physical findings is not conclusive. More often than not tumors of the ureter and bladder are not associated with any abnormal physical findings unless the latter infiltrates the base of the bladder when induration may be palpable above the prostate.

Examination of the urine serves only to differentiate hematuria from hemoglobinuria, clots and microscopic red blood cells being absent from the urine in hemoglobinuria. The literature which antedates cystoscopy contains a good deal of misinformation; thus it has been stated that shadow forms of erythrocytes in the urine point to a renal origin and that angle worm clots suggest that the blood was molded in the ureter. The former may result from the bleeding into the bladder in the presence of residual urine and the latter

* Given before the Aberdeen District Medical Society at Aberdeen, South Dakota, on November 29, 1950.

Head of the Division of Urology in the Department of Surgery at the University of Minnesota, Minneapolis.

may be molded in the urethra.

Similarly, before the days of accurate diagnosis a good many tests were developed, based upon the patient's voiding into a series of glasses, sometimes as many as six being used. Anything of this type more complicated than the two glass test is rarely used today and one must never base a diagnosis upon the findings of a two glass test. The reasons therefore are readily apparent when one considers the following facts: When both glasses are uniformly bloody, one cannot tell whether the bleeding has its origin in the upper urinary tract, in the bladder, or in a fairly active hemorrhage from the prostate sufficient to permit mixture of the blood with the urine in the bladder.

When the first glass is bloody and the second is clear, one may be dealing either with scanty bleeding from the prostate which settles in the urethra and is washed out with the first urine; or oozing from a vesical papilloma so that the blood settles and is washed out with the first urine.

When the first glass is clear and the second bloody, one cannot tell from this test alone whether the blood at the termination of urination comes from contraction of the inflamed prostate with resultant cracking of the mucosa or whether a papilloma is pinched at the end of urination.

It is evident from these considerations that definitive measures must be taken to ascertain the source of the bleeding. The sequence which should be followed depends first upon whether the patient is bleeding when first seen; if so, and there is no contraindication to cystoscopy such as an acute inflammation with fever or the presence of a distended bladder, one does well to make a preliminary cystoscopy under local anesthesia simply to determine whether the bleeding is coming from the upper urinary tract or from the lower tract and if the former, which kidney is involved. Detailed investigation may well be deferred until later.

If the patient is not bleeding when first seen, or if the preliminary cystoscopy without other study demonstrates that the blood is coming from the upper urinary tract, the first step in the final investigation should be a good excretory urogram. This is of advantage both because it gives a good overall survey of the urinary tract, because it may make

the diagnosis and make cystoscopy unnecessary, or because it may cut down the number of cystoscopies necessary for a final diagnosis.

A good technique is essential in preparing the patient and exposing the film. The average patient requires a cathartic the night before the examination, and should take no fluid from then until after the X-ray in order to avoid unnecessary dilution of the excreted medium. The administration of a cubic centimeter of pitressin hypodermically 45 minutes before the dye is injected will result in much greater freedom from troublesome shadows of gas and feces, but only if the patient goes to the toilet after the drug begins to work (severe hypertension and coronary disease contraindicate its use). The judicious use of firm compression over the lower abdomen, with a roll of cloth between the anterior superior spines and a good compression band, will greatly improve delineation of the renal pelves and ureters. After the upper ureters have been seen, at least one film is exposed immediately after release of the compression in an effort to visualize the lower ureters.

One film should invariably be exposed before the contrast agent is given, or stones may be concealed by the excreted medium. The contrast agent should be injected as soon as this film has been exposed, because apprehensive patients swallow air while waiting for something to happen — and the resultant shadows may be troublesome. My own preference is for Neoipax, because I know of no fatalities from its use. The common burning in the vein may be obviated by rapid injection. Patients with known allergies are better studied with retrograde pyelograms because of the danger of severe reactions from any of the contrast agents.

If the excretory urogram does not show a definite source of bleeding, a cystoscopic examination must be done, if feasible under anesthesia, so that the examiner will not feel obligated to hurry, and so that the resultant relaxation will permit the painstaking scrutiny necessary to find small tumors. The instrument used should, of course, permit examination of the urethra as well as of the bladder. One must bear in mind the fact that a neoplasm of the bladder too small to produce a filling defect in the urogram may be the source of bleeding. The same thing is true

of a small tuberculous cavity in the kidney. If the urethra and bladder are normal, retrograde pyeloureterograms must be made unless the details are perfectly shown in the urogram. It is desirable too, in all cases in which the studies up to this point have not revealed clearly the lesion causing the bleeding, to collect urine from each kidney for injection into guinea pigs in order to exclude an occult renal tuberculosis. Moreover, cystoscopy and bilateral retrograde pyeloureterograms should be repeated in six to twelve weeks in those cases in which thorough study does not result in a definite diagnosis. One should not be content with a diagnosis of essential hematuria, atypical hemorrhagic diathesis, or of similar obscure conditions without a careful and detailed follow-up.

It is not feasible in the time available to discuss all possible causes of hematuria, so I shall content myself with an outline of them, and will discuss only a few important details.

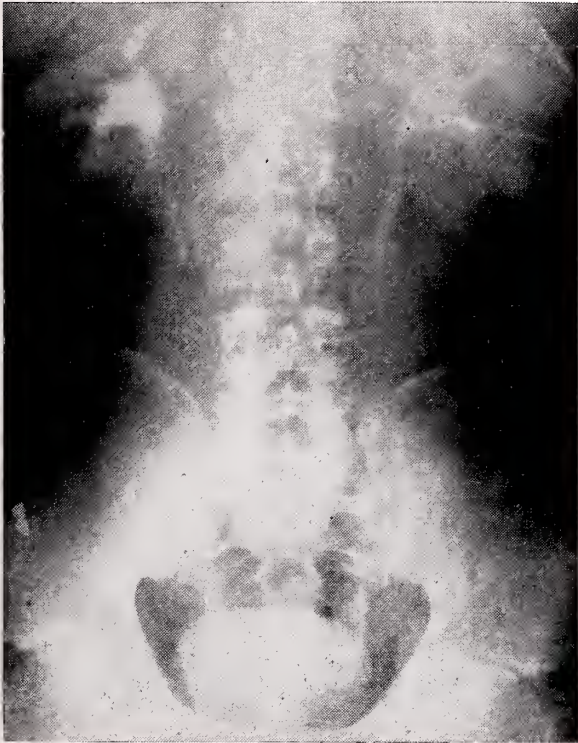


Fig. II

A diagnosis of bleeding due to an haemorrhagic diathesis can be sustained only if there are other evidences of it, such as petechiae in the skin, bleeding from the mucosal surfaces, or alterations in the bleeding, clotting, or prothrombin times. This is an uncommon cause of blood in the urine. Heparin and di-

coumarol come into question nowadays.

The bleeding cannot safely be attributed to nephritis unless the whole picture (blood pressure, eye-grounds, edema) is typical.

Hematuria due to renal or ureteral calculi is usually scanty and associated with colic, but may be fairly profuse and painless. Even a transparent calculus will usually be demonstrable with careful pyeloureterograms. (figure two)

Early renal tuberculosis may present hematuria as its only symptom, and is usually recognizable as a small excavation in the cup of a minor calyx. (figure three) The diag-

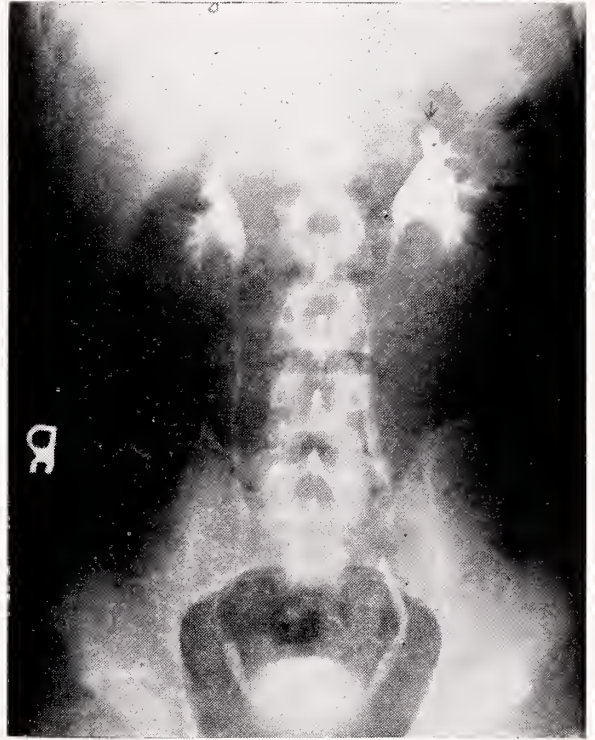


Fig. III

nosis wants bacterial confirmation (sterile urine even when pus is present, acid fast bacilli). The more advanced lesions are easily recognized on pyelography. (figure four)

Renal neoplasms are usually readily identified at pyelography, but a globular, encapsulated lesion may be mistaken for a solitary cyst, even by an experienced urologist. (figure five to seven) If the patient is a good risk, surgical exposure of the kidney is indicated in the presence of any uncertainty. If he is a poor risk, aspiration biopsy is of immense value. The ability to collapse the mass by aspirating clear fluid and to visualize it by directly injected contrast agent pretty well

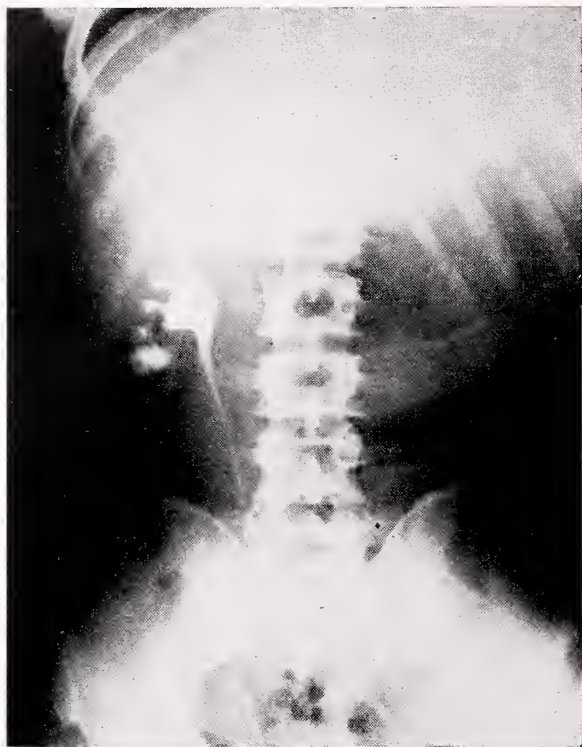


FIG. IV

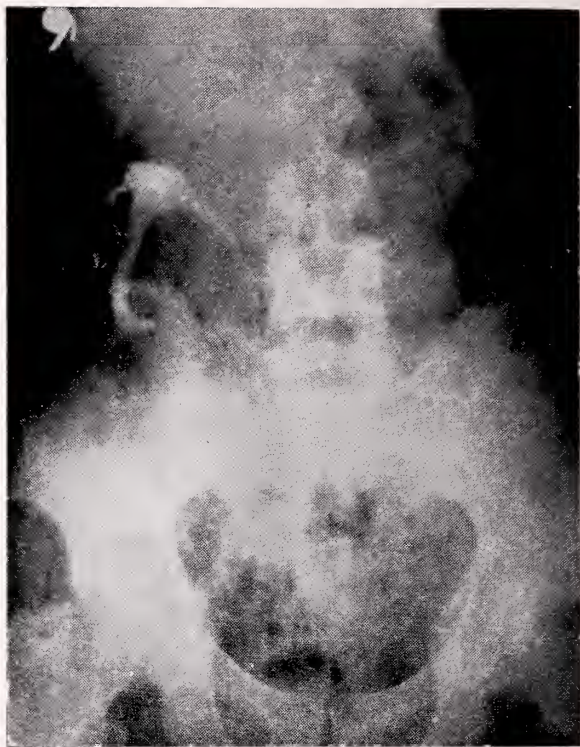


Fig. VI

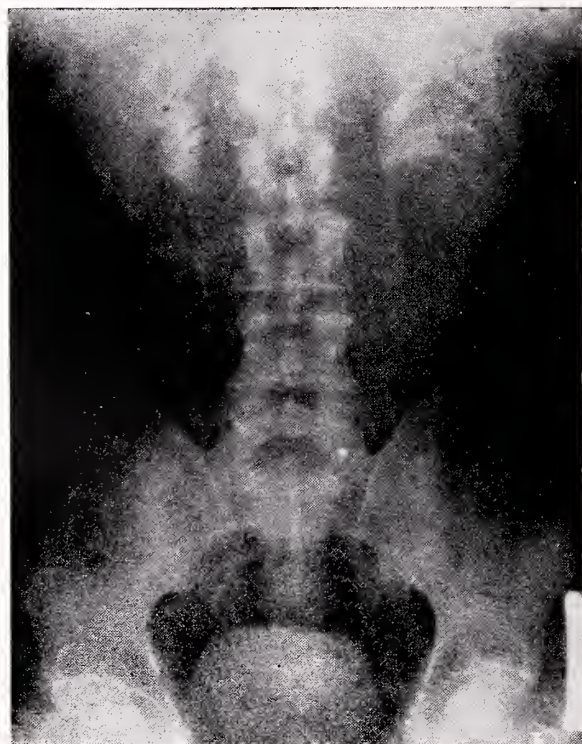


Fig. V



Fig. VII



Fig. VIII

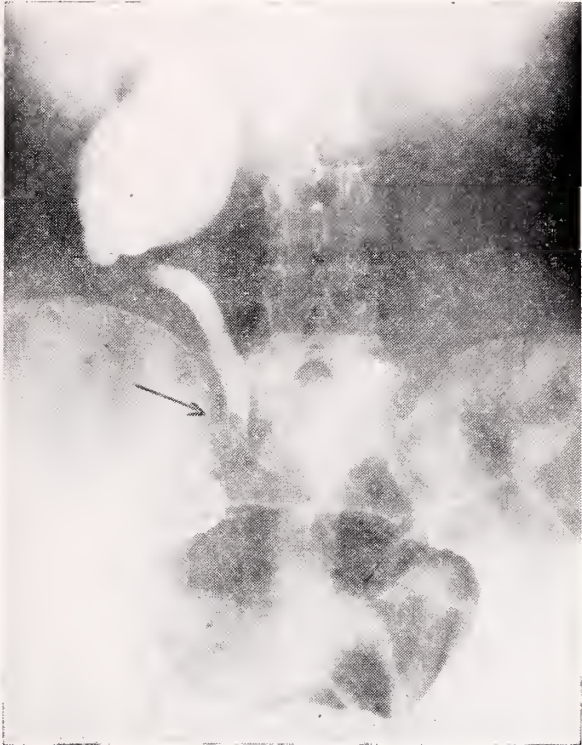


Fig. X

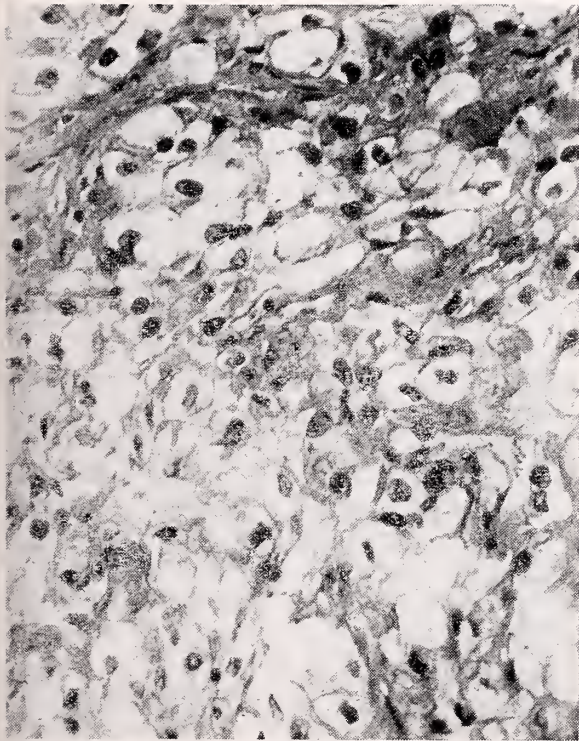


Fig. IX

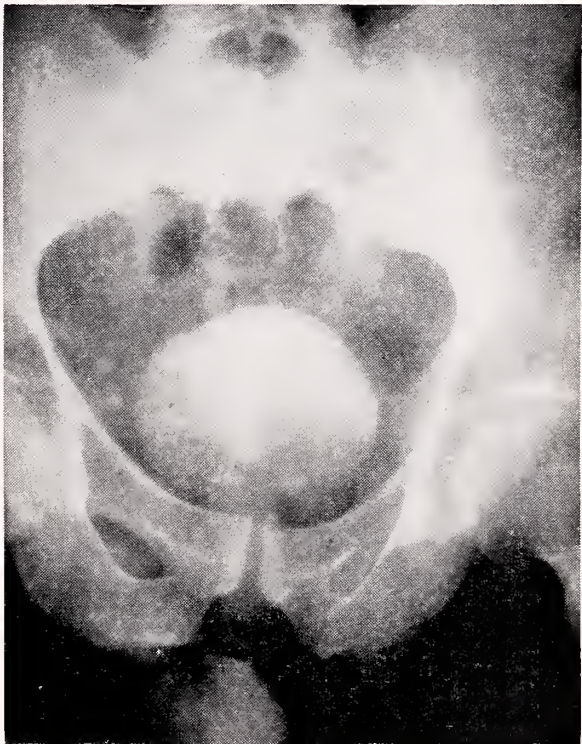


Fig. XI

excludes neoplasm. (figure 8) The very rare cystic tumors usually contain cloudy or bloody fluid. If no fluid can be obtained, the contents of the needle should be ejected onto

a slide, fixed, stained, and examined, and will often permit a diagnosis of renal neoplasm. (figure 9)

Ureteral neoplasms, while rare, usually ap-

pear as filling defects in the ureterogram, and are readily recognizable if borne in mind. (figure 10)

Vesical growths are easily found at cystoscopy whether they show in the urogram or

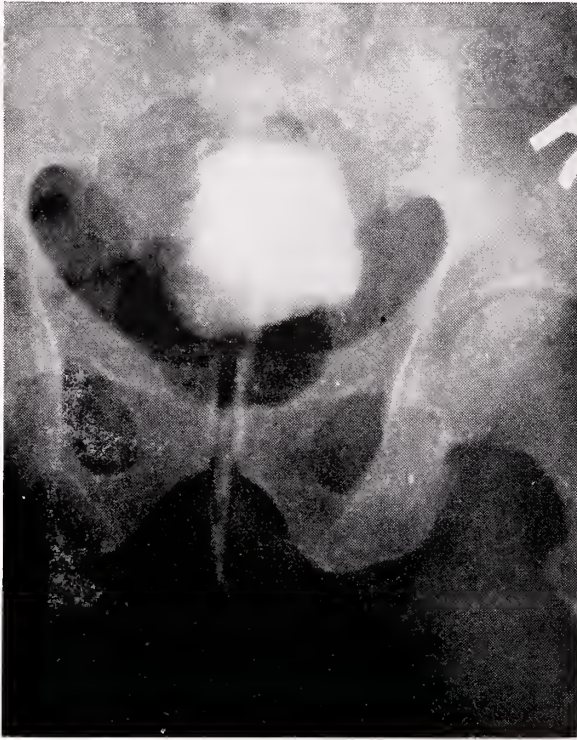


Fig. XII



Fig. XIII

not, and should always be subjected to biopsy in order to avoid embarrassing errors. (figure 11 and 12) When such a lesion is suspected but not found, a retrograde cystogram is in order to make sure that one has not overlooked a diverticulum containing a tumor. (figure 13)

The bleeding from vesical calculi is usually scanty, terminal, and associated with terminal dysuria and suprapubic pain on jarring, but all of these symptoms may be absent if the stone is cushioned by residual urine. Ten to fifteen per cent of vesical calculi are transparent to the X-ray. Some of these may be touched with a sound, and so identified, but cystoscopy is always needed.



Fig. XIV

Foreign bodies behave like stones, are often transparent to the X-ray unless encrusted, and since they are usually introduced by masturbation or result from a surgical mishap, the patient rarely knows or admits their presence until they have been found by the examiner. They should be considered whenever vesical irritation and pyuria develop in a child or young person and prove resistant to good treatment. (figure 14)

When bleeding seems to be due to acute urethritis, cystitis, or pyelitis, antiseptics or antibiotics should be given until the acute irritation has subsided, at which time the investigations outlined above should be made. Cystoscopy during an acute cystitis or urethritis is likely to be followed by a severe

(Continued on Page 289)

McKenna Clinic

Early Diagnosis of Acute Abdomen*

By R. E. Greenfield, M.D., Sioux Falls, S. D.

Edited by A. K. Myrabo, M.D.

McKenna Hospital

It is obvious to everyone that time limitations makes an adequate discussion of this topic rather hopeless. However, some years ago while doing a little work in the library at Cook County Hospital, we discovered what was to us a rather unusual condition; i.e., of the various pathological processes that cause abdominal distress, those which are most frequently misdiagnosed were only 6. And these 6 abdominal conditions which constitute the majority of misdiagnoses in an acute abdomen are also very common conditions. Therefore it behooves us to review them occasionally because they can be differentiated. If the differential points are kept in mind, early diagnoses can be had in practically every case. They are not uncommon at all. In fact, the most common is acute appendicitis, acute cholecystitis, then ruptured peptic ulcer, acute pancreatitis, renal colic, and lastly acute coronary occlusion. The later is not an abdominal condition but, it does produce an abdominal picture and acute abdominal distress. All of us are guilty of developing bad habits and probably the worst is that we fail to follow routine in diagnosis. We are called to see an ill individual. He tells you he has a belly ache. We look at his abdomen. We send him to the hospital. We start ordering laboratory tests, then some other one, X-rays and we don't follow the teaching which all of us know to be accurate. As a result we occasionally slip up. If we do always take a history, if we always form a definite symptom complex in our mind on that particular patient, if we then proceed with our physical examination and last and certainly the least resort the various laboratory tests, we will make fewer misdiagnoses and we will

reach a conclusion accurately and correctly more quickly than the other method.

I hope you're not insulted by a quick discussion of appendicitis because actually as we see more of it we respect it more. The patient with appendicitis will tell you that something he ate gave him a belly ache. The vast majority of acute appendicitis cases can be diagnosed with the asking of two questions. If you simply ask the patient where the pain started and if the answer is here or all over the abdomen and then if you ask him where it is now and he points to his right lower quadrant, the majority of cases are acute appendicitis and can be diagnosed with no further questioning at all. There are few other points that should be mentioned and we're not going to be thorough with this at all, but every case of acute appendicitis has anorexia.

Any man who tells you he had bacon and eggs for breakfast and had a good beef roast for lunch and enjoyed every bite of it does not have appendicitis. He probably has more of an acute gastromegalic distress than acute appendicitis because any time the appendix becomes distended the reflexes are originated which cause loss of appetite. The same symptom to a greater degree is nausea and to still greater, vomiting. The latter two are the exception to the rule because before the patient reaches such a state the process has progressed beyond acute appendicitis into peritonitis or into an abscess which is not considered in this same category. Another thing that is frequently misunderstood is fever. Acute appendicitis does not produce fever in adults. One last point to make and that is the blood count. Doctors get into more trouble because they respect a normal white blood count probably more than any other laboratory test. It is very dangerous to put much faith in a normal white blood count.

* Presented at the McKenna Hospital Annual Staff Clinic Meeting, Nov. 29-31, Sioux Falls, South Dakota.

Instead if you will pay more attention to the poly count, other than to the shift to the left or differential count, they're going to be far more accurate in their diagnoses and they're going to be far less chagrined in any type of abdominal distress especially in a elderly persons. That's another pitfall into which we all fall.

Gall bladder disease is found in the so called very fat, fertile, phlegmatic, flabby forty year old female with 4 kids. And this type of patient is not a coincidence because gall stones are developed as a result of something. There are obviously exceptions to this rule but it is the woman who is pregnant, who eats a lot of fat, and who digests a lot of cholesterol who develops a hypercholesterolemia anemia which in turn coats the lining of the gall bladder which forms polyps which in turn break off and form gall stones. Therefore, it is not difficult to understand why certain women have gall stones and why those women are those that present this picture of acute gall bladder disease. Any women in the middle age who have frequent attacks of abdominal pain requiring hypodermic shots of morphine or similar drugs have gall bladder disease until proved otherwise. These other conditions that we're going to discuss do not fit that picture. The history that a woman will give you having gall bladder disease is that of gastric dyspepsia, with fats and fried food, cucumbers, raw apples and cabbage. Those four things. Old Christian Fair used to keep apples in his office and if the patient could eat a raw apple she wasn't suffering from acute gastric dyspepsia. He told her she didn't need her gall bladder removed. He claimed any patient who could eat a raw apple could keep her gall bladder and not suffer serious consequences. We don't hold to that fast rule anymore. But, it is something that can be remembered. The pain of gall bladder disease is characteristic. It is found under the right costal margin and it is referred frequently to the stomach. That is confusing because when it is referred to the pyloric end you get pyloric spasm and are confused with the possibility of a duodenal ulcer. When it is midgastric, it is difficult to differentiate from gastric carcinoma. When it is a cardio spasm you may be confused with coronary disease, you may be confused with diaphragmatic hernia, you may be

confused with other left sided pathological processes. Six weeks ago at McKennan Hospital, I took a gall bladder out of a lady who also had a diaphragmatic hernia. She had left sided symptoms. She had pain, etc., all on the left side, in addition to her typical gall bladder trouble. It is probable that her left sided symptoms were due to the gall bladder but, not knowing for sure, we were forced to repair the diaphragmatic hernia at the same time the gall bladder was removed to have a reasonable assurance that postoperatively she would have a comfortable course. But, you can have confusing pictures. In addition to referred pain, the pain may radiate along the course of the 7th intercostal nerve and you have pain at the inferior angle of the scapular. You do not have pain in the right shoulder from a gall bladder disease any more than you have pain in the shoulder from a fractured right leg. Because, it is anatomically impossible. It is more or less a myth but some doctors still feel that the pain in the right shoulder indicates gall bladder disease. If, in the case where you do have a bad gall bladder and you do have pain in the right shoulder it is very highly suspected that gall bladder has become gangrenous, that it is ruptured, that there is biliary peritonitis. Fever is common in an acute cholecystitis. The reason for that is that the gall bladder does not have a submucosa and that toxic products are rapidly absorbed and you simply have a pyrexia as a result of these toxins. Tenderness is common in the right upper quadrant in an acute gall bladder. However, sometimes it is difficult to differentiate an appendix from an inflamed gall bladder and there are two things that help. Normally, the abdomen is tympanitic in all four quadrants on percussion. When you have an acute cholecystitis the right upper quadrant is usually dull. On the other hand, with an appendix the right upper quadrant is usually tympanitic even when the appendix is the cause of the distress. One other thing hyperesthesia of the skin which in turn is due to an inflamed organ underlying that particular part and can be detected by simply picking it up and it can be outlined accordingly. It is usually positive below the naval in appendiceal disease and above the naval on the right side in gall bladder disease. It is highly unreliable, but it is something to be remem-

bered. X-rays are indicated always when in doubt of gall bladder disease.

Perforated ulcer is found in men who have ulcer histories with which you are probably acquainted. The picture is typical. They have sudden severe pain in the upper epigastrium. Usually with the ingestion of foods or liquids they go into a sort of shock-like stage. You have all seen them. Most important of course, is the abdomen. There are differentiating signs. The abdomen feels like your arm when you contract the muscle it's hard. The most important physical sign probably, in addition to that is the absolute silent tomb like belly on hospitalization. You can not have bowel sounds in a frank massive ruptured peptic ulcer. If bowel sounds are present the diagnosis of a frank peptic ulcer rupture is in doubt. Next, the gastric bubble usually is released into the peritoneum cavity and you have the loss of liver dullness on percussion. X-rays are frequently used to detect this pneumoperitoneum in the region of the liver. It is important to mention that the **Forme Fruste** type of ulcer will frequently cause chagrin and wonder on the diagnostician's part because the patient in this case has sudden severe pain in the upper epigastrium. The ulcer is almost immediately sealed by internal or external gastric substances and the patient is able to stand up, he's able to walk, he's able to straighten, the bowel sounds are present, the other signs are not present, and you are rather perplexed. However, if the possibility is kept in mind the diagnosis usually can be reached by exclusion and it is important to remember the possibility because if you don't refrain from treating that patient, the next time he eats, the ulcer will possibly burst wide open, and you will have a frank perforation.

Acute pancreatitis is found in heavy set women around the age of forty. The pain is similar to that of an ulcer and usually starts after meals. It hits them in the center and then it radiates bilaterally as a rule into both loins so that the pain distribution is that of an inverted fan, it goes through the back as all pancreatic disease frequently does and the patient will be seen lying on her stomach or sitting up because she immediately discovers that the pain is decreased by not lying on her back. They will practically always vomit and wretch in this very severe con-

dition. One possible help is that fifty percent of these patients are jaundiced, not greatly, but at least the jaundice can be detected on laboratory studies. You frequently have to use exclusion in this condition to make your diagnosis. However, laboratory tests are probably more important in this condition than in any of the others because a serum amylase frequently goes up high and soon serum calcium goes down below nine soon. It is confused most often with perforated of the pneumoperitoneum especially.

Renal colic is not always due to kidney stones. It may be due to blood clots, it may be urinary debris. It may be due to inspissated pus. It may be due to a kink in the ureter, the so called Dietl's crisis.

No man, middle aged, who has a clean tongue, who has a slow pulse, and who has a pain in the abdomen has renal colic until proved otherwise. The pain is characteristic, you know all about it. It starts in the kidney region and projects mesially and inferior. The urine signs include blood; frequently there is pus; frequently there is albumin although not always. X-rays are important in this state. This patient shows a different picture from those with peritonitis. He is climbing the wall, he is bouncing off the ceiling, he is rolling in bed, he is very active, he's usually vomiting. The diagnosis is not usually difficult. X-rays are important. As I mentioned, if they are negative on the plate intravenous pyelograms can be used safely and with good benefit. More often for prognostic information than otherwise.

Acute coronary thrombosis again hits the men, usually again around 40. These patients have cardiac histories, a little dyspnea on excursion, a little orthopnea and hypertension. If you question them you'll find that they have the typical sudden attack, pain usually in the chest usually radiating up into the shoulders and sometimes down into the abdomen. They frequently have nausea and sometimes vomit. Their abdominal complaints are occasionally the major ones. There are other signs however, that are usually found. They may be cyanotic. They are extremely anxious. They give you the picture of a man who's scared that he's going to die. The pulse is weak. The heart sounds are feeble and usually may be rapid and

(Continued on Page 289)

PRESIDENT'S PAGE

D. A. Gregory, M.D.

OCTOBER MESSAGE

SOCIALIZED MEDICINE — A BENEFIT?

The subject of socialized medicine is still a highly controversial one. The high cost of medical care is one selling point of those advocating it. They shout of cost on every occasion but fail to give the hospitalization expense full credit for its share, yet hospital bills nearly always exceed the physicians fee. This fact escapes their notice. On the other hand, they do not recognize that free service of a doctor does not afford the protection it seemingly offers. It can and often does hinder it. An overload of patients assigned to doctors working under such a system results in less particularized attention. In his address to the A. M. A. June 1951, Dave Beck, Executive Vice President International Brotherhood of Teamsters (A. F. L.) put the question this way: "This problem of bringing medical care to all citizens of this country is one of the most pressing, and, at the same time, most troublesome problems we have ever faced. It is difficult to solve because it involves two fundamental concepts which they say cannot be reconciled: first free enterprise, the right of the doctor to practice his profession as a free man in a free society, and second, the right of the people of the nation to have available to them, and within their economic reach, all of the medical care and attention which are necessary to keep them in the highest state of health known to science. We must find some plan whereby free enterprise is preserved and wherein the health of the nation is safe guarded and strengthened. Socialized or federalized medicine is not the answer. The voluntary way is the "American Way."



How about our voluntary protection versus socialized medicine? According to the report of the Health Insurance Council as given in the A. M. A.'s secretary's letter of 9-14-1951, "at least half of the nations population at the end of last year (1950) was covered by one type or another of voluntary protection against the economic hazards of sickness and accident." Hospitalization coverage at the end of 1950 was (17%) seventeen percent greater than the coverage at the end of 1949. Nearly 77 million people had hospitalization expense insurance; over 54 million had surgical expense coverage. Moreover "growing public appreciation of the advantages of voluntary health protection can be seen in the fact that the number of people protected against hospital costs has more than doubled since the end of World War II."

In the matter of cost of service it is evident to the alert inquirers that the physicians care takes the smaller part of the total expense under either plan. The English have finally realized that they cannot afford to make available the unbridled use of their National Health Service and have ordered that 50% of the cost of dentures and spectacles must be paid by the patients. Their doctors have demanded increased fee rates. The president of the London area of the British Medical Association is reported to have said that out of the weekly contribution to national insurance the family doctor received less than three cents or less than the cost, in England, of one cigarette. He also stated that he could not recall a single promise made by the politicians to both doctors and patients that had been kept. Their patients have noted that the increased number of patients includes chronic complainers who utilize time needed for the really sick. Some politicians will promise anything and the greatest promisers are those trying to socialize the practice of medicine.

That there is need of improving our system of caring for the health of the nation none of us will deny; but, under the American Voluntary plan even the needy have a better chance for expert care in the U. S. A. than anywhere else on earth.

EDITORIAL PAGE

QUACKERY IN SOUTH DAKOTA

South Dakota, like any other State, has its quota of quacks and charlatans calling themselves "doctor" or merely professing to cure ailments of all kinds. Several of these have become increasingly bold of recent months and now advertise in the public press.

One individual in South Dakota claims a treatment from which "you will be successfully cured in a few weeks." Then are listed the diseases which will be cured . . . "Heart diseases and circulatory troubles, nervous disorders, digestive troubles, rheumatism, arthritis, female trouble, gland sickness, swollen tonsils, bronchitis, sinus, stiffness of the neck, hemorrhoids, hay fever, etc." Sort of a — you got it, I'll cure it — arrangement.

This individual, and others claiming such wonders must be stopped. The Board of Medical Examiners is prepared to crack down on these people if proper proof of illegal practice can be obtained. Every legitimate practitioner of the healing arts in the State should be on the lookout for these people.

Maintain good medical practice by helping stamp out the illegal practitioners. Notify the Board when you have something.

SUPPLEMENTARY REPORT OF SECRETARY-TREASURER 1950-51

INCOME

Balance on Hand		
May 1, 1951	\$868.85	
Received from Executive		
Secretary Foster	100.00	
Interest — U. S. Bond	12.50	
Total	\$981.35	\$981.35

DISBURSEMENTS

Secretary's Salary		
(April-May)	\$100.00	
Stenographer	20.00	
Postage & stationary	3.16	
Social Security Tax	1.50	
Total	\$124.66	
Balance on Hand		
August 1, 1951	856.69	
Total	\$981.35	\$981.35

R. G. Mayer, M.D.

GULLIBLE'S TRAVELS

July 31 — I drove to Chamberlain to discuss association matters with **Bob Beckwith**, manager of the Chamberlain Hospital, and with **Doctors Holland** and **Binder**.

August 2 — drove to Pierre to talk to Attorney General's office on the mental health clinic — back again the same day.

August 4 — Loaded the family into the car and lit out for the Michigan lake country and two weeks of vacation.

August 15-16 — Attended a meeting of V.A. medical officers and Medical Association Home Town Care plan representatives in Detroit. Met **Dr. R. A. Culbertson**, formerly of Sioux Falls but now in Des Moines. Discussed plans for changes in the operation of the V. A. plan.

Arrived home on the 19th and fought with piled up office work until Saturday the 25th when I drove to Huron to hear Harold Stassen expound his theories.

Monday, August 27, **Drs. J. V. McGreevey, F. E. Boyd**, and I drove to Mitchell to help celebrate the 40th anniversary of **Dr. W. A. Delaney's** practice there. The affair was held at the Mitchell Country Club which was packed with the doctor's many friends.

August 30 — Attended the regular monthly meeting of the Board of Directors of the Sioux Falls Mental Health Center where **Dr. James Maddux**, USPHS, Kansas City, was a guest.

On September 4, I drove to Pine Ridge to address the Lions Club on Heart Association aims and activities. As soon as I finished talking, I drove to Chamberlain to spend the night and then hurried to Flandreau where I talked to the Kiwanis Club at the request of **Dr. Mac Benjamin**. Home the next day to meet with V. A. officials to discuss changes in the Home Town Care Plan as suggested at the Detroit meeting. Decided no change should be made at the present time.

For better than a week I was able to do office work and then the travels started again.

September 15 saw me accompanying **Dr. L. J. Pankow** to Huron for an evening meeting of the Medical School Affairs Committee which is now headed by **Dr. C. B. McVay** of

Yankton.

The next afternoon saw the Council in full swing — the minutes are reported elsewhere.

On the 20th I drove to Pierre to spend an hour with **Governor Anderson** discussing medical matters. Same afternoon, I stopped to visit **Dr. Kenneth Kaisch** in Phillip and pulled into Rapid City later that evening. Talked to several local doctors by phone but couldn't arrange my schedule to meet with them.

Spoke at the luncheon meeting of the state convention of Realtors and then lit out for Newell to discuss DP doctor licensure with **Lynn Gladstone**, editor of the Newell Irrigator.

Returned to Rapid City to hear **Mr. Cal Snyder** of the Washington office of the National Association of Real Estate Boards speak on the situation as he saw it in Washington.

Sept. 22 — With **Tony Westra** ass't. vice-president of the Security National Bank, I returned to Sioux Falls to relax for what was left of the weekend.

MINUTES

COMMITTEE ON MEDICAL SCHOOL AFFAIRS, MEDICAL EDUCATION AND HOSPITALS, SEPTEMBER 15, 1951 HURON, SOUTH DAKOTA

The meeting was called to order at 7:30 P.M. by Chairman McVay. Present were: Drs. McVay, Price, Brown, Slaughter, Pankow, Williams and Executive Secretary Foster.

On motion reading of the minutes was dispensed with because of publication in the Journal. The Executive Secretary read the financial report of the Medical School Endowment Association.

A discussion was held on investment of funds and government bonds and Executive Secretary Foster was instructed to make such investment. Discussion of the relationship between the A. M. A. Endowment Fund and the South Dakota Endowment Association ended with no action.

Slaughter brought up the matter of handling of the clinical clerkships. Committee agreed unanimously to continue present procedure. The committee agreed further to recommend a second letter of solicitations for funds be sent out in mid-November.

There being no further business the committee adjourned on motion at 11:00 P. M.

MINUTES OF THE COUNCIL MEETING HURON, S. D. — SEPTEMBER 16

Meeting was called to order by chairman Van Demark at 1:15 P. M.

The Secretary called the roll: officers present were: Gregory, Jernstrom, Mayer, Pankow, Foster and Goldsmith. Councillors present were: Alway, Davidson, Morrissey, Gillis, Reding, Van Demark, Quinn, Lampert, Buchanan, Pfister, Peeke, and Brown.

Alway moved that the reading of the minutes of the previous meeting be dispensed with, seconded by Davidson and carried.

The Chairman asked for Old Business and the matter of Basic Science Board appointments were discussed by the executive secretary — Pankow moved that the council endorse the following resolution:

Whereas: the operation of the South Dakota Board of Examiners in the Basic Sciences has been brought to the attention of the South Dakota State Medical Association, and

Whereas: the Council of the Association has made a complete study of the situation

THEREFORE BE IT RESOLVED that the South Dakota State Medical Association endorse and commend the Board for its Equitable treatment of all applicants for certification under the Basic Science law, and

BE IT FURTHER RESOLVED that this resolution be forwarded to the Governor of the State of South Dakota and any other individuals wishing information on the results of this study.

Seconded by Davidson and carried.

The executive secretary brought up the matter of a fee schedule for the Indian Service and read the recommendation of the Committee on Medical Economics.

Alway moved acceptance of Committee report approving fee schedule. Seconded by Morrissey and carried.

Lampert moved that the executive secretary be instructed to carry on negotiations with the Indian Service to report to the Council in January. Seconded by Quinn and carried. There was no further old business.

The Chairman asked for new business.

Alway nominated Dr. John Bruner, formerly of Frederic, now of Aberdeen for General Practitioner of the Year. Dr. Peeke

moved that the nominations be closed and unanimous ballot be cast for Dr. Bruner. Seconded by Davidson. Carried.

A resolution of the Pharmaceutical Association was read concerning clinic pharmacies: Gillis moved that the resolution be tabled pending further study. Seconded by Alway. Carried.

The Association president requested the Districts to submit names of possible Annual Meeting speakers.

Buchanan moved that the Association not accept sponsorship of school health broadcasts on station KUSD. Seconded by Davidson. Carried.

Mayer moved endorsement of principles suggested by Industrial medical groups to AMA Council on Industrial Medicine. Seconded by Pfister. Carried.

Mayer moved that balance of secretary's account be placed in the Association savings account. Seconded by Peeke. Carried.

Mayer moved that Dr. Agnes Keegan be named an honorary member of the Association. Seconded by Peeke. Carried.

Mayer moved recommendation of Drs. D. H. Briet and W. A. Dawley to Cancer Commission. Seconded by Gillis and carried.

Pankow moved that the president, president-elect and vice-president be notified of all committee meetings. Seconded by Jernstrom. Carried.

Reding moved that Dr. L. F. Beall of Irene be named an honorary member of the Association. Seconded by Davidson. Carried.

Mayer introduced a Mr. Quinn who discussed the possibilities of Blue Cross — Blue Shield program for South Dakota.

Pankow moved reference of suggestion to Insurance committee. Seconded by Lampert and carried.

On motion the meeting was adjourned at 3:40 P. M.

HOW THE MARKET "WORKS"

One of the great phenomenon of stock investing or speculation is the ready willingness of people to put their money in stocks although they have little or no knowledge of how the market actually "works."

A business or professional man faced with an expenditure of \$5,000 or \$10,000 for his business, for insurance or even his home will usually think about it for a long time and

will hesitate to proceed until he has examined every possible factor effecting the expenditure.

But this same person will, if he gets the notion, put the same amount of money in the stock market with the very minimum of thought and planning. The result, of course, leaves much to be desired more often than not.

The Three Trends

The single most important factor to recognize about the market is that there are 3 trends in force at all times.

These are the primary, secondary and minor trends. The primary trend is what carries prices up or down for a number of months or years; the secondary trend is the counter or corrective move in the opposite direction, lasting from 3 weeks to 3 months, and the minor trend is the day by day movement which is of little or no importance.

Unless investors or speculators are willing to ride their stocks up and down and run the risk of severe loss (today's "good" company may be tomorrow's "casualty") consideration **must** be given to these three trends — especially the all important primary trend.

The primary trend is like the tide of the ocean. When it is up, it carries all prices with it with very few exceptions; when it is down, all prices tumble.

Therefore, it is easy to see that the very first necessity for successful stock buying and selling is to buy when this trend is pointing up and sell and keep out of the market when it is pointing down.

Thousands of words are written every day, year in and year out, about individual stocks — how good their earnings are expected to be, how their prospects are, what they are planning to do, etc., — but if this primary trend of the market is down, the would-be investor would be far better off in his rose garden than under his reading lamp.

General Trend More Important Than Individual Company Statistics

Everyone knows there are differences in companies which will be ultimately reflected in the price of their stocks but there is not one company in a hundred that can be so good as to buck the primary trend of the market.

99 out of 100 stocks will go down with the "tide" so why buy a stock at 50 if it will be available at 30 later on? The real "good" ones

may not go down as much as the others, but down they will go with the main trend.

The point to be made here is that success in the stock market does not depend on "picking" individual stocks correctly as so many feel but rather on being "intune" with the primary trend of the market. When it is up, stocks should be purchased and held for they will go up; when it is down, they should be avoided as if they were the black plague for they will decline and there is nothing that can be done about it.

Some investors prefer to "ride out" these primary downtrends but they usually don't do it more than once. The ride down is much more painful than originally anticipated and there is always the danger that the stocks held will not "come back." History is full of just such instances.

How To Detect Trends

The question arrives, naturally, as to how to know whether the market is in an upward or downward phase.

There are two methods of trying to do this. The first is to study the market yourself, keeping a chart of the "averages" (Dow-Jones Industrial and Rail Averages which are the standard yardstick for stock movements) which will show you what is going on. The second is to employ a dependable counsellor to give you guidance.

Both have their advantages and disadvantages and sometimes a combination is the right answer.

In any event, the fact that these trends do exist must be recognized at the beginning of any investment program and must never be forgotten by anyone wanting to make more than he loses in the stock market.

The more recognition of the existence of these trends of the market are not any guarantee against loss but is most certainly a good beginning toward successful investing (that many never accomplish) and then when the problem of keeping in tune with these trends is solved, the investor is well on his way to success.

INVESTMENT TRUSTS MUTUAL FUNDS

One of the great financial inconsistencies prevalent among both professional and business men in America is their ability and willingness, on the one hand, to work hard

and long to make money and their absolute refusal, on the other hand, to admit that it takes as much thought and effort to keep it as to make it.

In all too many cases, a person who has literally spent the best part of his life accumulating money feels that his job is over and that somehow or other, the task of keeping it is of minor importance and should be delegated to someone else.

Nothing is farther from the truth as an examination of past history will show. Less than half of the people who make money succeed in keeping it and the reason most of them lose it is because they won't work as hard to keep it as they did to make it.

This universal desire to fight only half the personal financial battle is one of the main reasons for the popularity of investment trusts and mutual funds.

In the majority of cases, the person who buys stock in an investment trust or fund does so in an attempt to relieve himself of the responsibility and work of watching his own money.

Often, he doesn't have more than the vaguest idea what investment trusts are, the difference between them, the purposes of the various types or their past record. Too often, he buys such shares simply because he feels they are run by smart men who will handle his money for him successfully. Needless to say, the conservation of capital is rarely accomplished by having such blind faith in others.

In fact, such blind faith often leads to the expectation of miracles from the "smart" managers but, as many trust share holders found out from 1929 to 1932, these shares go down with all others and there is nothing the managers of them can do. And, like many other firms, they even go broke during declining markets and periods of business depression.

However, once it is recognized that trusts are not a magic means to a lifetime of sure income and sure capital safety (they all own stock and thus their stocks fluctuate with the general market) there is no reason why a certain part of an investment fund cannot be devoted to them if so desired.

Two Types of Trusts

Basically, there are two types of trusts: closed-end and open-end. The closed-end

trusts derive their name from the fact that they have a relatively fixed amount of their own shares outstanding and available to buyers. The entire sum to be managed is raised by a single offering and after that, investors wishing to buy the shares must buy from those willing to sell in the open market.

The closed-end type is sub-divided into two types: leverage and non-leverage. The leverage closed-end trusts are often used as a speculative media as these shares will generally far outpace the general market both up and down.

Anyone buying this kind of a trust for an "investment" is most certainly in for some surprises of his life.

Generally speaking, the non-leverage trust is sounder and a little more stable than the leverage. At least, the fluctuations are not so wide.

The second type of trust is the open-end trust, often referred to as a mutual fund. The name is derived from the fact that the company continuously offers new shares to the public and as new funds are received from investors, these funds issue new shares and invest the sums received.

The open-end funds are probably the most stable of all the trusts but on these, the cost is figured on net asset value plus a specified selling charge that is usually around 8%.

This selling charge is considered by many as too heavy a penalty to pay for fund management and generally a good investment service can be bought for less and, if the fund is above \$25,000, the services of a personal counsellor can be obtained at a saving.

Space does not permit much details here on individual trusts but the thing to remember about all trusts is that they buy stocks with your money the same as you would and they are subject to the same market changes as you would be yourself whether you were working alone or with the aid of a service or counsellor.

If this factor is recognized and the time taken to investigate thoroughly the different types of trusts and the individual companies (What is their investment policy? How big is it? How old? What is the past record?), they most certainly can serve as a media for investments.

But they — like all other investments — should not command too large a portion of

the entire investment fund and, of equal importance, they deserve a continuing interest. If this latter is not given, the final result must, like in all other investments that are ignored, be disappointing.

MICHIGAN DECISION KEEPS CHIROPRACTOR OFF HOSPITAL STAFF

Circuit Judge Thomas J. Landers of Gogebic County, Michigan, recently brought out a few facts regarding chiropractors practicing in hospitals.

The chiro in this case had brought criminal charges against the trustees of a hospital in Ironwood, Michigan claiming that they discriminated against him and wilfully neglected to perform duties while holding positions of public trust when they refused the use of Grandview Hospital for his chiropractic practice.

Here are the salient points of Judge Landers' decision:

1. . . . "a public officer cannot be subjected to criminal prosecution for failure to perform duties which require the exercise of discretion on his part, where there is no element of an evil or corrupt design in his conduct."
2. The chiropractor "claims to be a practitioner of a school of medicine, . . . but we are referred to no statute or case where the legislature or a Michigan court has ever defined the meaning of the term 'school of medicine'."
3. . . . "To uphold the informations and force the defendants to trial in these cases would be legislating that the term "school of medicine" included a school where chiropractic was taught."
4. The Board of Trustees were given the authority to determine rules for the hospital. The rules state that no person shall practice medicine in the hospital unless he has a license from the state of Michigan to practice medicine.

NEWS NOTE

Dr. D. S. Berkman has associated with Dr. A. A. Lampert of Rapid City. His practice will be limited to internal medicine.

This is



OCTOBER
1951
Vol. 4 No. 10

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Mental Health Group Starts Minnehaha County Unit

A mental health center will open in Sioux Falls on a limited basis around January 1, 1952.

Plans call for the center to provide a community mental health out-patient clinic for the treatment of patients with personality disorders, counseling services to organized health and welfare agencies, education for mental health, and to provide for pre and post-hospitalization care for mental hospital patients.

According to the by-laws of the organization, treatment will be provided for anyone desiring care irrespective of ability to pay. It is presumed that a nominal fee will be charged those with ability to pay.

The organization has a Board of Directors made up of fifteen members representing as many city, county, and state organizations. Board members have approved a start with a psychiatrist, psychiatric social worker, and an office clerk on a limited budget. Present budgeted income will amount to \$22,000.00 with an additional \$17,000.00 needed for

full operation.

Present plans call for all personnel to meet the standards for professional personnel as recommended by the National Mental Health Council. Again, it is presumed that the Board may see fit to adapt its rules to cover lesser qualified personnel in order to start the program operating.

Finances for the center will come from the State Department of Health, the City of Sioux Falls, the Community Chest and the Board of Education. Revenue from fees is expected to implement this income slightly.

ABERDEEN DISTRICT HEARS SCHEIFLEY

Dr. Charles Scheifley of the Department of Internal Medicine, Mayo Clinic, was the principal speaker at the first monthly meeting of the Aberdeen District Medical Society for this season.

Dr. Scheifley spoke on "Unusual Aspects of Coronary Disease." The meeting was held at the Sherman Hotel with about twenty members in attendance.

"UTERINE BLEEDING" IS PECKHAM SUBJECT AT YANKTON MEETING

"The Management of Uterine Bleeding" was the subject of a paper presented at the Yankton District Medical Society Meeting at Sacred Heart Hospital in Yankton October 3. Dr. B. M. Peckham of the Department of Obstetrics and Gynecology at Northwestern University Medical School discussed the subject before twenty five members of the Society.

A dinner was held at the hospital for members and the auxiliary. Dr. E. R. Schwartz, president of the District introduced the speaker and several guests.

ADDITIONS TO ROSTER SINCE AUGUST ISSUE

J. H. Hoskins, M.D.
Sioux Falls
R. A. Weber, M.D.
Mitchell
R. W. Barr, M.D.
Sioux Falls
O. P. Erickson, M.D.
Lemmon
M. A. Warpinski, M.D.
McLaughlin
R. W. Hayes, M.D.
Winner
T. B. McManus, M.D.
Milbank

NEWS NOTES

Karl M. Forster, M.D. has associated with **Drs. Smith and Hill** in Yankton.

Terence McManus, M.D. has taken over the practice of **Kurt S. Tauber, M.D.**, Milbank, who passed away recently.

Dr. Olin Odland has joined the staff of **Watson Clinic** in Brookings.

Dr. Chris Pascuzzi is now associated with **Dr. Robert Quinn** in Sioux Falls.

Dr. R. D. Green, Medical Director of the Veteran's Administration in Sioux Falls, and **John C. Foster**, Medical Association Executive Secretary attended a conference on V.A. Home Town Medical Care Plans in Detroit August 15 and 16.

Dr. Fred M. Rich, Jr., M.D. has established a general practice in Elk Point.

Dr. John Tidd is practicing pathology in Yankton.

Dr. Robert Bray has recently associated with **Dr. Holleman** in Rapid City.

Dr. John Gridley has joined the staff of the Medical Arts Clinic in Watertown, he will do general practice with emphasis on Ob. and Gyn.

Dr. John Jestiadt has associated with **Doctors Totten and Steiner** in Lemmon.

Dr. Charles Mitchell is the new pathologist at Sioux Valley hospital replacing **Dr. James Clarke**.

Dr. John Feeham, Jr. has established general practice in Rapid City.

DIABETES DETECTION DRIVE SET SOON

Diabetes week, November 11-17, will spearhead the

American Diabetes Association's nationwide Diabetes Detection Drive — the fourth sponsored by the association.

The year-round Diabetes Detection programs, approved by the American Medical Association, is the only broad health education and case finding program developed exclusively by the medical profession. Its objectives are two-fold: (1) to further the detection of diabetes among the public; and (2) to disseminate general information about the disease.

Twenty-eight state medical societies (including South Dakota) and over 500 county medical societies have established Diabetes Committees. Ten of the twelve district societies in South Dakota have established such committees.

OMAHA MIDWEST SET FOR OCT. 29-NOV. 2

The Omaha Midwest Clinical Society will hold its annual meeting at the Hotel Paxton in Omaha October 29 to November 2 inclusive.

Speakers include Drs. Mitchell Rubin, Buffalo; Harold Boyd, Memphis; Roland Mackay, Chicago; Maxwell Wintrobe, Salt Lake City; Louis Limarzi, Chicago; Edward Boland, Los Angeles; Arthur Grollman, Dallas; Louis Katz, Chicago; I. S. Ravdin, Philadelphia; Vincent O'Connor, Chicago; George Crite Jr., Cleveland; Louis Bauer, New York; Lawrence Boies, Minneapolis; Theodore Squier, Milwaukee; Comm. E. P. Cronkite, Bethesda; and Franklin Payne, Philadelphia.

CHEST PHYSICIANS SET L. A. MEETING

The Interim Session of the American College of Chest Physicians will be held at the Ambassador Hotel, Los Angeles, California on Dec. 2 and 3, 1951. On Sunday, December 2, a scientific session will be presented sponsored by the California Chapter of the College, including round table luncheon discussions and an x-ray conference. A banquet will be held in the evening. The Board of Regents of the American College of Chest Physicians will meet on Monday, December 3, as well as various councils and committees of the College.

ARMOUR STAGES INTERNATIONAL SYMPOSIUM ON CHEMISTRY OF ACTH

Armour and Company sponsored an international symposium in the Palmer House, Chicago, Sept. 18 at which leading European and American biochemists discussed the chemistry of ACTH.

The conference followed within a few days the Jubilee meeting celebrating the 75th birthday of the American Chemical Society, together with the meetings of the International Chemical Congress and the International Chemical Union, in New York and Washington.

Many prominent foreign chemists were in the United States for these sessions, most of them as guests of American chemical and pharmaceutical organizations. Armour research di-

vision, headed by Victor Conquest, vice-president, has interested itself especially in three younger men, two English and one Swedish, who had never before had the opportunity to meet American biochemists.

These three are: George W. Kenner, chemist, and Fred Sanger, biochemist, both of Cambridge University, England; and Jerker Porath, biochemist of Uppsala University, Sweden.

Topflight visitors also included: Prof. Arne Tiselius, biochemist of the University of Uppsala, Sweden, winner of the Nobel prize in chemistry in 1948; Prof. A. R. Todd, Cambridge biochemist; and C. J. O. R. Morris of the London, England, County Hospital.

Presenting formal papers were: Prof. David F. Waugh, biochemist of the Massachusetts Institute of Technology; E. B. Astwood, Tufts College, chemist; Emil M. Smith, M.D., and Prof. George W. Sayers, biochemist, both of the University of Utah; Prof. Sidney W. Fox, biochemist, Iowa State University; Prof. Wendell M. Stanley, C. H. Li and J. Ieuan Harris, biochemists, and Fred W. Carpenter, virologist, all of the University of California.

Wilfred White and Joseph D. Fischer, biochemists of the Armour and Company research division, also delivered papers.

"One of the most important chemical frontiers is the structure of proteins," Mr. Conquest explained.

"We feel certain that bringing together a group of men

so outstanding in that exploration as these men are for exchange of ideas and discussion will advance the whole process tremendously."

KURT S. TAUBER, M.D.

Dr. Kurt S. Tauber, aged 50 passed away at Milbank on August 2. His body was placed in the family lot in Yankton.

Born in Austria, Dr. Tauber practiced in Akron, Ohio; Wagner, S. D., and at the Yankton State Hospital. He moved to Milbank in 1946 after his marriage to Marjorie Campbell Adams of Yankton. His widow and two small daughters, Katherine and Virginia survive him.

Dr. Tauber was a member of the South Dakota and American Medical Associations and was a psychiatric examiner for the Veterans Administration.

MRS. L. M. RIGGS DIES AT 93

Mrs. Louisa M. Riggs, 93, mother of Dr. T. F. Riggs of Pierre, passed away at Oahe, Mission near Pierre.

Mrs. Riggs came to Dakota Territory in 1868 with her father, Captain Javan Irvine, who was stationed at Fort Sully, 30 miles north of Pierre. She was educated in the east and returned to teach at the Oahe Mission where she met and married Rev. Thomas L. Riggs.

In addition to Dr. Riggs, a past-president of the South Dakota State Medical Association, she is survived by sons Robert and Lawrence, both of Pierre.

F. A. NORTHRUP, M.D. DIES IN ILLINOIS

F. A. Northrup, M.D., formerly of Pierre, passed away at Quincy, Illinois in August. Dr. and Mrs. Northrup had been making their home with their daughter, Mrs. Mercedes Root.

Dr. Northrup, an honorary member of the Association, died at the age of 83.

P & H ANNOUNCES NEW LOCATION

The Physicians and Hospital Supply Company has recently announced its new location at 1400 Harmon Place which gives them over twice the floor space that they previously had. The new place has 70,000 feet of floor space on five levels.

The Company has invited all South Dakota doctors to see their new facilities when visiting in the Twin Cities.

INTERNATIONAL MEETING

American Academy

of

Pediatrics

20th Annual Meeting

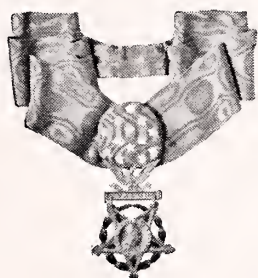
Royal York Hotel

Toronto, Ontario

Canada

OCTOBER 20 to 25

Medal of Honor



Sergeant Charles Turner, of Boston, Massachusetts—Medal of Honor, Korea. On September 1, 1950, near Yongsan, Korea, Sergeant Turner took over an exposed turret machine gun on a tank. Despite fifty direct hits on the tank, he stayed by his gun and destroyed seven enemy machine gun nests before he was killed.

You and your family are more secure today because of what Charles Turner did for you.

Sergeant Turner died to keep America free. Won't you see that America *stays* the land of peace and promise for which he gave his life? Defending the things he fought for is *your* job, too.

One important defense job you can do *right now* is to buy United States Defense* Bonds and buy them regularly. For it's your Defense Bonds that help keep America strong *within*. And out of America's inner strength can come power that guarantees security—for your country, for your family, for *you*.

Remember when you're buying bonds for defense, you're also building a personal cash savings. Remember, too, if you don't save *regularly*, you generally don't save at all. So sign up in

the Payroll Savings Plan where you work, or the Bond-A-Month Plan where you bank. For your country's security, and your own, buy United States Defense Bonds!

****U.S. Savings Bonds are Defense Bonds - Buy them regularly!***

The U. S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America as a public service.



PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor

Interprofessional Relations*

By Dr. L. J. Pankow

I want to compliment you on your program, very few errors. My initials are L. J., as you notice under the picture which you were kind enough to print of me; and since the 5th day of this month, I have been the immediate past president of the South Dakota State Medical Association. Outside of that, it is correct.

I was going to start by saying "My friends" but despite the fact that the druggists and physicians are, and must of necessity, be friends, I just don't like the annotations that might be attended to the term — so I am going to say "Ladies and Gentlemen." It is true that we should be friends, and I think essentially we are. There are degrees of friendship, however. We are both courting the same public, the same "girl friend" you might say. We get them for what's the matter with them, and you get them for giving them what is going to help them.

I was very interested in part of your president's talk in regard to barbiturates. We are troubled with the same problems that you are. They come in and cry on our shoulders, they can't sleep. I have a little stock phrase that I tell those people. It might help you. I tell them, I have never known anyone to die from lack of sleep, but I have known of lots of them to die from too many sleeping pills. This proposition of being friends and having the same "girl friend" and so on reminds me — and seriously this will be the only story I will tell you because this is too serious a subject. "Two old buddies were standing on a street corner talking, and a couple of ladies came down on the other side of the street. They looked and one of the fellows said, "Well, there comes my wife and my mistress." The other one said, "Well,

you took the words right out of my mouth." So, let us be friends, but not quite that friendly perhaps.

The subject, I don't know where it came from. I don't know if I was silly enough to suggest this to our friend, Tom Haggard, or whether he suggested it to me, "Interprofessional Relations." We can't help but have relations because, as I said, we are both courting the same girl, therefore, as would be the case in a great many other things, if we have any relations at all, we must have problems — so I tried to find out what some of these problems might be. I talked with a number of my medical friends over the State. I talked to every druggist I could buttonhole, and asked both of them what gripes they had against the other. I told them why I wanted to know. I don't know whether you druggists just love us completely because I had an awful job getting any gripe; or whether you are afraid to make any comments that might be considered criticism of our august fraternity and so on and so forth. But, if we are friends, we should be frank and open with each other. So, I asked the druggists that I could get a hold of, what some of their pet gripes were. I am not going to make any claim of being a brilliant orator, but what I am going to say, I hope, makes a little sense and I assure you it's sincere as I see it.

One druggist complained because doctors passed out samples that they received from the retail men. Well, I can see a legitimate gripe there, if it is carried too far, but looking at it from the other side of the picture gentlemen, we are sampled, sampled, and sampled. We have preconceived ideas of certain things and many of them find their way into the waste basket. If you gentlemen were talking about the barbiturates, it is a rule in our office that practically every sample of any

* Presented at the South Dakota Pharmaceutical Association Convention at Watertown, June 1951.

medicine that comes in with phenobarbital added, and goodness knows they are getting it into everything but beer now days, goes into the waste basket, and we do not prescribe it. If we want a person to have barbiturates, we will give them, but on the other hand there are many things that come into our hands that might be good. We don't know much about them from first hand experience, they have glowing accounts of what they will do, what things they will cure, and all that sort of thing. Many times I would not have started using a drug on a prescription, a pill, elixir, or what have you, had I not first been sampled with sufficient amounts to try it out on a patient or so. Consequently, when I found it was good, you boys from then on got business from that particular sample. There is one thing that is more infuriating — I have been approached on the subject. A druggist comes up and wants to buy the samples from the doctor. I assure you that never occurred to me. I rather think that is going a little too far — that, then, is the opposite gripe. So much for the passing out of samples.

We, too, are harassed by laws, restrictions and regulations; and we know pretty well what your laws, rules, and regulations are too in regard to narcotics and barbiturates. One of the gripes was that the Doctors phone in prescriptions for narcotics and barbiturates. We know and appreciate that we are wrong in doing so, and that you are wrong in filling them. There is many a slip between the cup and the lip; and it could conceivably happen that a prescription get lost in the mail when you do mail it to us. I promised you I wouldn't tell you another story, but this one just occurred to me. The chap had his girl out in his beautiful shiny car on a lovely June evening, moonlight, parked up over a hill, looking over the lake. He slipped his arm over her shoulder, drew her to him, and said, "Honey, will you marry me?" She said, "I will tell you when you get home." After some urging, he quickly started the car, drove home, pulled up in front of the house, stopped the car and she got out. He said, "Well, what is your answer?" She said, "Of course I will marry you." "Why wouldn't you tell me out to the lake?" She said, "Twenty-four years ago Dad took Mother out to that same place on that lake. It was just such a night as this. Dad proposed to Mother and she accepted;

and on the way home the horse ran away and Dad was killed." So it could happen that something might go wrong and you boys would be the ones left holding the sack. We should not make a habit of phoning prescriptions in that can be given personally. I can't speak for the entire medical profession, of course, but our effort is to try and get the patient to come in for a prescription, if for no other reason than that we can get a look at them; size them up, see how they are doing, and also see if they actually need something or not. There are exceptions, of course.

Two other gripes that have been rather common are telling the patient to go and buy some certain medicine rather than giving them a prescription. That may have some legitimacy in being a gripe and it may not. I do not believe you make any less on a product that is bought over the counter; and you do save filing space for your prescriptions and all that. Of course, I am leaving out those things which are supposed to have prescriptions, such as antibiotics, sulfas, phenobarbitals, etc., which we know you are not supposed to fill. Having seen many cases of self medication before the sulfas were put on the restricted list, and having seen some unfortunate and unhappy followups of this harmless drug anahist, etc., I think that point should be pretty well taken. I do not think we should encourage patients to go and buy something over the counter.

Another gripe is the dispensing doctor. As I was setting over here beside your friend Tom, and your President spoke of price wars and price cutting etc., I said, "I don't suppose you have much trouble with price cutting do you?" Tom said, "Sure we do, just the same as anybody else," and I said "You probably know who they are too, most of them, they are the same fellows that dispense in their office." Now there may be a reasonable excuse for some of these men dispensing in their offices, reasons at least. There is the type of doctor who has grown up in the old school. They are fast dropping out now. He felt that no one could prepare his medicines for him. He got into the habit of putting up his own medications. Perhaps there was no druggist immediately available where he was practicing and necessity got him into a habit which he has never broken. I don't believe that group is bothering you very much. Then

there is the group that figures, "Well, these druggists are making all kinds of money, I don't know why they buy aspirin for eight cents a hundred and sell it for one dollar and fifty cents a dozen. Why shouldn't I get in on that? Why should I give all that to the druggist?" The modern doctor is not dispensing very much. It is more the older type, the type that is the nickel pincher that is going to cut prices to get business; and I don't know if anyone can do much for that kind of a fellow. I am not sure you would appreciate or enjoy his prescriptions if you got them. There is a third type of thing that has a tendency to stimulate dispensing, I am sure it doesn't happen very often in South Dakota, where the druggist charges just inordinate prices. There are such places, you gentlemen know it, where you can't take a prescription for anything for less than two or three dollars, and some people just cannot afford to do those things. I don't know if anybody puts the initials PP on the bottom of a prescription anymore. Maybe, you fellows don't know what it means. Thirty odd years ago it meant that the patient was very poor, it was alleged that the druggist gave him the prescription at cost. I don't know if that exists anymore or not, but that is the reason for some dispensing. We realize that a patient is in such circumstances that he just can't afford certain prices.

There is a certain amount of griping on the part of the druggists because of a group or clinic having their own pharmacy. I am not an economist, I am not going to attempt to defend or decry the practice. I can say there are hospitals that have their own pharmacies and make a mighty handsome profit out of it. I know of a hospital who is charging more for their drugs in their own pharmacy than any drug store in our town. I know the Nurses there who have a discount at this pharmacy, go down town and buy over the counter at regular retail prices for less than they pay at the hospital pharmacy with their discount — so there are evils on both sides of that thing. I don't know that there should be a legitimate gripe against a legitimate clinic group, having their own pharmacy if they so choose, providing of course that a registered pharmacist is in charge of it. I think you would have every gripe in the world if they didn't have. It would be

equivalent to them doing their own dispensing. I bring that up only to mention that it is one of the gripes that has been presented to me.

I then asked the Doctors what gripes they had, and I didn't find too many. One great thing that we do resent and dislike is the habit that some of you have, and it is a human failing to help out some of our friends, somebody comes in and says that they have a bad cough and you go back and pick up a bottle of pine tar cough syrup, or something, and sell it to him over the counter. From our view point that is a great deal worse than it is for a doctor to dispense your products for the simple reason that it may be more than just a cough. Coughs may be purely symptoms of something much more severe. On the other hand if a person comes in and says, "I want a bottle of pine tar cough syrup," nobody can blame you for selling it. You have it there, it is merchandise, there is nothing illegal about selling it when it is asked for, but there has been a certain amount of dissatisfaction and griping with the idea of prescribing a medication for a patient. I mentioned about the inordinate charges that we don't like. We appreciate that we don't know very much about the merchandising game from your angle. We appreciate that there is much more to the cost of operating a pharmacy than buying a bottle of five thousand capsules and putting them in bottles and selling them out by the dozen. Most of us, if we stop to use our heads, would realize that, that prescription case of yours contains thousands of dollars worth, undoubtedly, of drugs, much of which is used but occasionally, but entails a capital investment which somebody just naturally has to pay for; and consequently the prescription must cost for a dozen aspirins a lot more than going and asking for a package of St. Johns.

One thing the doctors don't like, and fortunately I don't believe it happens much anymore, is substitutions. It may be just as good, but when we have told a patient that they are going to get pink pills and they call up and say, "I believe that druggist gave me the wrong thing because he gave me green pills" — if we have specified a trade name or a certain product, and the patient finds it to be a different color then we told him it would be, the patient is all in a dither,

and the doctor doesn't like it particularly well either. I haven't had a substitution for many, many years, that I know of. It has happened to me when I started out, and probably my old and very dear friend, Herman Krieser, thought I didn't know quite as much about medicine as he did, and maybe he was right. In fact, I am certain I didn't know as much about drugs as he did. I was sitting a bit ago with one of your members from Rapid City. He told me he used to work in Sioux Falls. We mentioned the name of a certain druggist there that I am sure a good many of you know, old Peter Bernhart. Another thing we dislike tremendously is to be called up and the druggist will say, "Doctor, I haven't got any one grain tablets, but I have half grains, now can I give him twice as many and tell him to take twice as many tablets." That gripes us, but just the same gentlemen, we love you for it because we know when you do that for us on a thing of that kind, you are not going to give them ASA compounds when we have ordered empirin compound and things of that sort, and perhaps we prescribed empirin compound because we think it is better, or another man may order PAC and so on and so forth and to each his own. We just love you even though you annoy us by that thing because we know then that you are not substituting drugs upon a prescription.

I thought I might be able to give a few suggestions that might help us get closer together in our two professions. The best way to get along with someone is to get to know him well. In my own profession there is a doctor practicing in Sioux Falls that at one time I disliked heartily. I couldn't see a thing nice about him, and I just didn't like him at all. I have been active in the State Medical Association for many years, and one year this man was elected to be a delegate to the State meeting also. It became quite natural that we rode up together in the same car; we got rooms right close together; we ate together; and we sat together during the convention meetings; we killed time together, and we went to the Stag together — and I found out there were just a lot of nice things about that fellow, and I have grown to like him greatly. So, the more we know each other, the more things we are going to find that we can like about each other; but we won't get acquainted if you don't make an effort to meet us and if

we don't make an effort to meet you. That probably can be handled well, and it is handled well by local druggists. A new doctor moves into a building, the druggists in the surrounding territory make it a point to go up and see him in a bid for prescription work. I think it should be more than that. I think it should be to actually and sincerely get acquainted; letting him know you wish to be of service to him by stocking any of his little pet medications, or putting up some of his favorite formulas. I think this thing that I mentioned about what we consider inordinate charges could well be brought out into the open and the doctors would understand much better why your charges are what they are, if you would allow such things to come up in your conversation with the doctors when you see them. Once in a while we drop in the drug stores, you know. That is our favorite hang out too. I think one way that these things could be better solved, and we could get better acquainted, is if the Doctors occasionally wrote an article in our Journal. We have a common Journal. If they would write an article that was informative for the druggists, and visa versa, if the druggists wrote an article once and a while to be published in the medical section of the Journal. Many of the druggists, as well as some of the physicians, have told me that they read my monthly letters in the Journal. Some of you were kind enough to comment favorably on them. Perhaps if your association president was to carry once a month a president's letter from the pharmacy association of South Dakota, a single page, a particular phase of something that might not only be of interest to the druggist, but informative to our profession, maybe some of us would turn over and read that too. We all like to read illustrated articles and stories, you know, and I am sure that is why they started reading mine because it had a funny picture up in the corner.

I can't answer for the entire state, what the doctors do in regard to the matter of interprofessional courtesy pertaining to charges. We feel quite indignant if we go into our favorite drug store and see a box of candy that is marked one dollar and fifty cents — or can you buy them for that any more — and the druggist says, one, fifty. We like to feel we are getting a discount.

Then, too, many times the druggist comes up to our office and is given an examination and he probably is charged just the same as anyone else. I don't blame you for having a gripe on that. Again, I can't answer for the entire state, or for the rest of the doctors in the state, but I can answer for myself. Druggists do not get charged as much as other people in my office because I do feel that they are a sister profession, or should I have said brother. The matter of discounts should be discussed with your doctor, I don't think many doctors would object, some few might.

There is one thing in my opinion that could create a great deal of good will between the two professions. I don't know where the idea ever came from, but patients seem to think, or have seemed to think in the past, that when I give them a prescription for something and they see the advertisement of somebody's drug store on the back, they turn it over and say, "Oh, do I take this to that drug store?" I make it a point to tell them that they can take it anywhere they want to. I have had this come at me then, "Well, I don't want to cheat you out of anything if you are getting a discount, a kick-back from this drug store — if so, I want to take it there." That is unfortunate. Maybe it use to be the habit forty or fifty years ago, I don't know, but unfortunately too many people feel that the doctor does get a kick-back on his prescriptions that are taken to a drug store. Maybe they think medicine couldn't possibly be worth that much, you had to give the doctor something out of it.

I have been mulling this thing over in my mind. You have a State Association, you undoubtedly have a seal, or you could put up a little card on your prescription counters, stating you were a member of the South Dakota Pharmaceutical Association; then on the back of your prescription blanks, it was printed, "Take this prescription to any drug store that displays this sign, or this emblem." On the cover put all the advertising for the doctor that you want, but instead of the individual drug stores furnishing prescription blanks — we are awfully glad to get them — having on the prescription blanks no individual advertising, but advertising of the pharmacy association as a whole. It would alleviate any question on the part of the patient that the druggist was charging more

so he could give a kick-back to the doctor. It would elevate your association standards to the extent that those of you who belong to the association would have something to prove it hanging on your prescription case; and it would be just a little added evidence of quality, and your qualifications and ability and right to fill those prescriptions.

I think probably that I have taken enough time and haven't said too much. I wonder if there might be any question or any comments that anyone would like to fire at me that I might be able to clear up or answer. It was a pleasure and a privilege, as well as an honor, to have been invited to speak to you this morning. I hope it may have brought our two associations into, I shouldn't say more friendly relations, because we have been very friendly, but should we say perhaps a bit more understanding relations. We are brothers under the skin, aiming at the same things in life, trying to make a living out of our knowledges and skills from the same source. Again, I thank you very kindly for this privilege.

NEWS NOTES

Dr. Gerald A. Fostvedt, M.D. gave an address before the Fifth District Meeting of Boards and Colleges of Pharmacy in Rapid City on June 25, 26. His topic was on the extemporaneous prescription writing by physicians.

Frank J. Wilson who was Pharmacist Manager of the Wm. S. Goins store in Kadoka passed away July 21, 1951. Mr. Goins is interested in employing a pharmacist to manage his place of business.

Calvin Estwick has purchased the Swenumson Store at Sisseton, South Dakota.

Ron Parks formerly at Dunning Drug, Sioux Falls, S. D. has purchased the store at Valley Springs from **D. E. Rourk**.

Roger Koenig has purchased the Hagggar Sioux Valley Drug at Sioux Falls, S. D. from the A. K. Hagggar estate.

Carr Ross formerly pharmacist manager at Hall Drug, Sioux Falls is now pharmacist manager at Dunning Drug.

Fred Sackett is now Pharmacist manager at Ft. Pierre Drug.

Berton Lenker is pharmacist at Wallgreen Drug, Sioux Falls, S. D.

REVISED GUIDE IN MEASURING HUMAN BLOOD PRESSURE ISSUED BY A. M. A.

A revised guide for physicians in measuring human blood pressure has been issued by the American Heart Association. The guide, entitled "Recommendations for Human Blood Pressure Determinations by Sphygmomanometer," was published simultaneously in the October issue of "Circulation, the Journal of the American Heart Association," and the October 13th issue of the "Journal of the American Medical Association." It will shortly be available to physicians in booklet form through application to affiliated heart associations or to the American Heart Association's National Office, 1175 Broadway, New York 19.

The "Recommendations" replace the booklet "Standardization of Blood Pressure Readings," originally published by the Association in 1939. The revisions were drawn up by a committee appointed by the Council for High Blood Pressure Research of the American Heart Association, under the Chairmanship of Dr. Carl J. Wiggers, Professor of Physiology at Western Reserve University School of Medicine, Cleveland. The October issue of "Circulation" is dedicated to Dr. Wiggers to celebrate a half century since he began his work in the cardiovascular field.

In commenting on the publication of the "Recommendations," Dr. Wiggers said:

"The physician, and through him nurses and properly trained technicians, are being constantly kept informed of new discoveries which help to make blood pressure readings more accurate. The measurement of human blood pressure is still a comparatively new tool, the introduction of which is well within the memory of many of the older groups of practitioners. Recognizing that physicians were employing different techniques and criteria in measuring blood pressure, and too generally assumed that instruments sold were accurate, the American Heart Association in 1939 appointed a committee to crystallize the best available thought on the subject at that time by publishing a pamphlet entitled 'Standardization of Blood Pressure Readings.' This has resulted in more precise standardization of methods and has stimulated manufacturers to make improvements in apparatus.

"Since that time, more experience has been

gained in laboratories and hospitals, resulting in even greater accuracy in measurement of human blood pressure. This has now been assembled in the new 'Recommendations.'"

HEMATURIA — — —

(Continued from Page 270)

local reaction. The traumatic type of urethritis is common in the female.

In conclusion, some hematuria may occur in benign hypertrophy and carcinoma of the prostate, but one should not attribute it to one of them until other causes have been excluded, remembering that prostatism usually occurs at an age when neoplasms of nearly all organs are most common.

SUMMARY AND CONCLUSIONS

Hematuria is so often a sign of serious disease that it always demands a complete study of the urinary tract including urograms and cystoscopy, before it can be dismissed as trivial.

ACUTE ABDOMEN — — —

(Continued from 273)

occasionally they are irregular. The white blood count will go up later.

Reviewing these 6 conditions which constitute a large percentage of abdominal cases, reminding us of the different possibilities and the reasons, you can make an early diagnosis. If you don't miss any of them, you needn't be chagrined if you do miss an occasional rare pathological process causing abdominal distress.

PHARMACISTS RECENTLY LICENSED BY EXAMINATION TO PRACTICE IN S. D.

(Continued from August Issue)

- Duane Albert Roberts, (S.D.S.C. 1951) Fulda, Minn.
- Rowland J. Roberts (S.D.S.C. 1950) Olson Rexall Drug, Flandreau
- Orville A. Rohlek, (S.D.S.C. 1950) U. S. Air Force, Scott Field, Ill.
- Charles R. Rush, (S.D.S.C. 1951) Bert's Drug Store, Anchorage, Alaska
- Leo J. Scherman (S.D.S.C. 1950) Knutson Drug, Clark
- Allen D. Shepersky, (S.D.S.C. 1951) Perriton Drug & Jewelry, Huron
- Lowell E. Sorenson, (S.D.S.C. 1951) Haggard Drug Store, Watertown
- Milton S. Swenson, (S.D.S.C. 1950) Kendall Drug Store, Brookings
- Bernard W. Tennyson, (S.D.S.C. 1950) Western Drug, Lead
- Theodore O. Torgerson, (S.D.S.C. 1951) Torgerson Drug, Amboy, Minn.
- Keith Verthein, (S.D.S.C. 1950) U. S. Army — Home - Holland, Minn.
- Kenneth R. Verthein, (S.D.S.C. 1950) Christgau & Douglas, Hutchinson, Minn.
- Wiley D. Vogt, (U. of Nebraska 1951) Yankton Drug Co., Yankton
- Richard J. Walcher, (Creighton Univ. 1951) Corner Drug Co., Pierre
- Floyd A. Wilkening, (S.D.S.C. 1950) Walgreen Drug, Sioux Falls
- Mrs. Carol Olson Youells, (S.D.S.C. 1950) Shirley Pharmacy, Brookings
- Kenneth A. Yunker, (S.D.S.C. 1950) Jones Drug, Aberdeen

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

PRESIDENT'S PAGE

of the Pharmaceutical Division

A. O. Bittner

OCTOBER MESSAGE

As mentioned in my August Message, comments on the Address given by Dr. Pankow to The Annual Convention of the South Dakota Pharmaceutical Convention this past June would be forthcoming. You have the opportunity to read his interesting paper on page 284 of this issue of the Journal. I urge every Doctor and Druggist to read it as I am sure it will do just exactly what the purpose and intent was when the assignment was given to Dr. Pankow, "Inter-professional Relations." Dr. Pankow was frank and truthful in all of the comments given, and that is what we as pharmacists especially were glad to hear. The applause given to the speaker certainly registered him as "King for the Day," if I am permitted to use that phrase. I cannot in this message give constructive answers to all of the gripes or problems that presumably exists among us, but will only entertain two and later entertain the others.



SAMPLES GIVEN TO DOCTORS AND PASSED ON TO PATIENTS:

From an economic view point, few if any, of the druggists object to the physician handing out samples to their patients. But they do object to handing out samples of "prescription only" drugs with the name on the package because of the confusion and misunderstanding this practice causes.

We, as druggists understand, that these new products, which our pharmaceutical suppliers wish to market or give a field trial, warrants in every way an ethical procedure. Samples that I have come in contact with are a medical therapy for only a short trial period and when used up the patient is to report back to the physician for him to judge results. Any continued use of this drug always ends up in a prescription given to the patient for continued therapy. Sometime the patient comes to the drugstore and wants some more of this sample, saying that, the doctor gave it to me, and it is so good. Well, what is our procedure? We as pharmacists say to the patient, who is your doctor? We inquire of the patient, if the doctor wanted you to report back to him when same was used up. Answer: "Yes he told me to get some more" Our next procedure is: We call the doctor and give him the story. He may want to see the patient to verify results, or he may O. K. a prescription over the telephone without further consultation. But under no circumstance give this patient the product without consulting with the doctor who gave it. If you do, it will bounce back at you, and the doctor will have a legitimate gripe and ill-feeling will be established. This is certainly not team-work on the

part of the druggist. Now, if the doctor ignores this cooperation on the part of the druggist and supplies the patient with further sample medication or supplies from his own stock, after this gesture was made by the pharmacist, surely then the pharmacist has a gripe. Practices of this latter type are not known to me. I have practiced pharmacy for 32 years, 26 of them in a small town and community under 400 population and have always enjoyed a good prescription business, I also looked out for the prescription needs of the practicing physician 100%, he did not have to contact other channels for his needs.

THE BARBITURATES

Even these products are sampled to physicians for an informative nature only. I do not believe that any physician passes these unto the patient knowing the danger involved. They end up in the waste-basket. When a physician deems it necessary to use them he wants them prescribed with specific instructions of the use thereof and a certain quantity for a certain period of time. If a refill is indicated such notice is given on the original prescription. Most all physicians now are very particular about any continued use of these products. Some patients have acquired too much knowledge about them, and use them for a means to end all trouble. As a result thereof protective measures had to be undertaken in the form of legislation, and I believe that all States have a Barbiturate Law defining definite procedures of use. These are to be observed 100% by the prescriber, the physician, and the pharmacist who fills the prescription. We as pharmacists should know our liability under the law, **NEVER** to refill a barbiturate prescription without the proper O. K. of the prescribing physician. **NOW** Doctors, give us this 100% cooperation and do not be offended when we call on you for an O. K. on a barbiturate prescription, we know that you are terribly busy and do not like to be bothered with an O. K. on some minor continued medications. We must observe the health laws and not make ourselves liable. Post-mortem findings of **self overdose** of the barbiturates leads to legal investigations, and a few of the druggists have already paid liabilities because they operated in a careless unauthorized procedure in supplying patients with these medicaments. We have only State laws to contend with at the present but if such controls are not sufficient, National Legislation similar to the Narcotic Regulations will be invoked. So DOCTOR-DRUGGIST Teamwork on this problem is so important, let us prevent in every way a South Dakota scandal of a barbiturate misuse.

A. O. Bittner, President

South Dakota Pharmaceutical Association.

FREE SAMPLE

DR. _____

ADDRESS _____

CITY _____ ZONE _____

STATE _____



AR-EX MULTIBASE

New Universal Ointment Vehicle Compatible with ALL Topical Medicaments

Prescribe ointments of cosmetic elegance — made with AR-EX Multibase. Applies readily, even to hairy areas, rinses off with plain water. No screening action, making all medicaments available.



AR-EX COSMETICS, INC.

1036 W. VAN BUREN ST. CHICAGO 7, ILL.

AUXILIARY ACTIVITIES

AUXILIARY ROSTER

DISTRICT #1 — ABERDEEN

Bunker, Mrs. Paul — Aberdeen
 Calene, Mrs. J. L. — Aberdeen
 Cooley, Mrs. F. H. — Aberdeen
 Eckrich, Mrs. J. A. — Aberdeen
 Gelber, Mrs. M. R. — Aberdeen
 King, Mrs. B. F. — Aberdeen
 King, Mrs. H. I. — Aberdeen
 King, Mrs. Owen — Aberdeen
 McCarthy, Mrs. P. V. — Aberdeen
 McIntosh, Mrs. G. F. — Eureka
 Mayer, Mrs. R. G. — Aberdeen
 Miller, Mrs. A. J. — Aberdeen
 Murdy, Mrs. B. C. — Aberdeen
 Murdy, Mrs. C. B. — Aberdeen
 Murdy, Mrs. Robert — Aberdeen
 Pittenger, Mrs. E. A. — Aberdeen
 Ranney, Mrs. T. P. — Aberdeen
 Rodine, Mrs. J. C. — Aberdeen
 Rosenberger, Mrs. H. P. — Aberdeen
 Rudolph, Mrs. E. A. — Aberdeen
 Scallin, Mrs. P. R. — Redfield
 Steele, Mrs. G. H. — Aberdeen
 VanSandt, Mrs. R. B. — Aberdeen
 Vogeles, Mrs. C. L. — Aberdeen
 Williams, Mrs. M. F. — Conde

DISTRICT #2 — WATERTOWN

Argabrite, Mrs. J. W. — Watertown
 Armalavage, Mrs. L. J. — Watertown
 Auskaps, Mrs. R. — Lake Norden
 Bartron, Mrs. G. R. — Watertown
 Bartron, Mrs. H. J., Jr. — Watertown
 Brown, Mrs. H. R. — Watertown
 Clark, Mrs. C. J. — Watertown
 Crawford, Mrs. J. H. — Watertown
 Jorgenson, Mrs. M. C. — Watertown
 Kilgard, Mrs. R. M. — Watertown
 Larsen, Mrs. M. W. — Watertown
 Magee, Mrs. W. G. — Watertown
 Maxwell, Mrs. R. T. — Clear Lake

Randall, Mrs. O. S. — Watertown
 Reul, Mrs. T. W. — Watertown
 Rousseau, Mrs. M. C. — Watertown
 Scheib, Mrs. A. P. — Watertown
 Stoltz, Mrs. C. R. — Watertown
 Stransky, Mrs. J. J. — Watertown
 Vaughn, Mrs. J. — Castlewood
 Walters, Mrs. S. J. — Watertown
 Willen, Mrs. A. — Clark

DISTRICT #3 — BROOKINGS

Austin, Mrs. D. C. — Brookings
 Baughman, Mrs. D. S. — Madison
 Baughman, Mrs. R. C. — Madison
 Benjamin, Mrs. M. B. — Flandreau
 Bakalinsky, Mrs. M. — Estelline
 Boyd, Mrs. F. E., Jr., — Flandreau

Davidson, Mrs. M. — Brookings
 Freifeld, Mrs. S. — Brookings
 Gulbrandsen, Mrs. G. H. — Brookings
 Henry, Mrs. R. B. — Brookings
 Hurewitz, Mrs. Marvin — Flandreau
 Patt, Mrs. W. H. — Brookings
 Peeke, Mrs. A. P. — Volga
 Plowman, Mrs. E. T. — Brookings

Scheller, Mrs. D. L. — Arlington
 Sherwood, Mrs. C. E. — Madison
 Tank, Mrs. M. C. — Brookings
 Watson, Mrs. E. S. — Brookings
 Westaby, Mrs. J. R. — Madison
 Whitson, Mrs. G. E. — Madison
 Wold, Mrs. H. R. — Brookings

DISTRICT #4 — PIERRE

Askwig, Mrs. L. C. — Pierre
 Collins, Mrs. E. H. — Gettysburg
 Cowan, Mrs. J. T. — Pierre
 Janis, Mrs. J. B. — Hoven
 Martin, Mrs. H. B. — Harrold
 Morrissey, Mrs. M. M. — Pierre
 Murphy, Mrs. J. C. — Murdo
 Robbins, Mrs. C. E. — Pierre
 Salladay, Mrs. I. R. — Pierre
 Simon, Mrs. S. B. — Pierre
 Spurbek, Mrs. G. H. — Pierre
 Swanson, Mrs. C. L. — Pierre
 Riggs, Mrs. T. F. — Pierre
 Van Heuvelen, Mrs. G. J. — Pierre

DISTRICT #5 — HURON

Adams, Mrs. H. P. — Huron
 Buchanan, Mrs. R. A. — Huron
 Charbonneau, Mrs. Y. H. — Huron
 Dean, Mrs. R. — Wess. Springs
 Gryte, Mrs. C. F. — Huron
 Hagin, Mrs. J. C. — Miller
 Hofer, Mrs. E. — Huron
 Hohm, Mrs. P. H. — Huron
 Hohm, Mrs. T. A. — Huron
 Jacoby, Mrs. H. — Huron
 Lenz, Mrs. B. T. — Huron
 Leigh, Mrs. F. — Huron
 Pangburn, Mrs. M. W. — Miller
 Saylor, Mrs. H. L. — Huron
 Saylor, Mrs. H. L. — Huron
 Saxton, Mrs. W. H. — Huron
 Tschetter, Mrs. Jos. — Huron
 Tschetter, Mrs. Paul — Huron
 Tschetter, Mrs. John — Huron

DISTRICT #6 — MITCHELL

Ball, Mrs. W. R. — Mitchell
 Bollinger, Mrs. Wm. — Parkston
 Bobb, Mrs. E. C. — Mitchell
 Delaney, Mrs. W. A. — Mitchell
 Delaney, Mrs. W. A., Jr. — Mitchell
 Delaney, Mrs. R. J. — Mitchell
 Dick, Mrs. L. C. — Spencer
 Fritz, Mrs. W. H. — Mitchell
 Gillis, Mrs. F. D. — Mitchell
 Gillis, Mrs. F. D., Jr. — Mitchell
 Hoyne, Mrs. A. H. — Salem
 Lewis, Mrs. H. R. — Mitchell

Lloyd, Mrs. J. H. — Mitchell
 Mabey, Mrs. O. J. — Mitchell
 Mabey, Mrs. D. R. — Mitchell
 Moran, Mrs. C. S. — Mitchell
 Murphy, Mrs. John — Mitchell
 Rieb, Mrs. W. G. — Parkston
 Skogmo, Mrs. B. — Mitchell
 Tobin, Mrs. F. J. — Mitchell
 Tobin, Mrs. L. W. — Mitchell
 Tomlinson, Mrs. W. — Mitchell
 Vonburg, Mrs. V. R. — Mitchell
 Weber, Mrs. R. A. — Mitchell

DISTRICT #7 — SIOUX FALLS

Anderson, Mrs. W. R. — Sioux Falls
 Arneson, Mrs. W. A. — Sioux Falls
 Barr, Mrs. R. W. — Sioux Falls
 Billingsley, Mrs. P. R. — Sioux Falls
 Billion, Mrs. T. J., Jr. — Sioux Falls
 Billion, Mrs. T. J., Sr. — Sioux Falls
 Brandon, Mrs. P. E. — Sioux Falls
 Breit, Mrs. D. H. — Sioux Falls
 Chalmers, Mrs. D. H. — Sioux Falls
 Clark, Mrs. J. C. — Sioux Falls
 Clarke, Mrs. J. Y. — Texas
 Cooper, Mrs. D. — Sioux Falls
 Culbertson, Mrs. R. A. — Iowa
 Dehli, Mrs. H. M. — Colton
 Donahoe, Mrs. S. A. — Sioux Falls

Driver, Mrs. D. R. — Sioux Falls
 Duimstra, Mrs. F. — Sioux Falls
 Eneboe, Mrs. E. E. — Alcester
 Ericksen, Mrs. E. E. — Sioux Falls

Ericksen, Mrs. O. C. — Sioux Falls
 Farrell, Mrs. H. W. — Sioux Falls
 Gage, Mrs. E. E. — Sioux Falls
 Green, Mrs. R. D. — Sioux Falls
 Greenfield, Mrs. R. E. — Sioux Falls

Greenough, Mrs. E. E. — Sioux Falls

Gregg, Mrs. J. B. — Sioux Falls
 Grove, Mrs. M. S. — Sioux Falls
 Hage, Mrs. W. J. — Sioux Falls
 Harris, Mrs. A. M. — Sioux Falls
 Harris, Mrs. M. A. — Sioux Falls
 Heib, Mrs. W. E. — Marion
 Hermanson, Mrs. J. M. — Valley Springs

Hofer, Mrs. E. J. — Freeman
 House, Mrs. R. — Sioux Falls
 Hyden, Mrs. A. — Sioux Falls
 Ihle, Mrs. C. W., Jr. — Sioux Falls

Kemper, Mrs. C. E. — Viborg
 Kilness, Mrs. A. W. — Sioux Falls
 King, Mrs. L. M., Jr. — Sioux Falls

Kittelton, Mrs. H. O. — Sioux Falls
 Kittelson, Mrs. J. A. — Sioux Falls

Kohlmeyer, Mrs. F. C. _____ Sioux Falls
 Lanam, Mrs. M. O. _____ Sioux Falls
 Larson, Mrs. C. S. _____ Sioux Falls
 Leraan, Mrs. L. G. _____ Sioux Falls
 Lindquist, Mrs. R. H. _____ Canova
 Manning, Mrs. D. H. _____ Sioux Falls
 Maresh, Mrs. E. R. _____ Sioux Falls
 McDonald, Mrs. C. J. _____ Sioux Falls
 McGreevy, Mrs. J. V. _____ Sioux Falls
 Myrabo, Mrs. A. K. _____ Sioux Falls
 Nelson, Mrs. J. A. _____ Sioux Falls
 Nessa, Mrs. N. J. _____ Sioux Falls
 Nilsson, Mrs. F. C. _____ Sioux Falls
 Ogborn, Mrs. R. J. _____ Sioux Falls
 Opheim, Mrs. W. L. _____ Sioux Falls
 Pankow, Mrs. L. J. _____ Sioux Falls
 Pullman, Mrs. N. K. _____ Valley Springs
 Quinn, Mrs. R. H. _____ Sioux Falls
 Rayburn, Mrs. F. W. _____ Sioux Falls
 Reagan, Mrs. P. _____ Sioux Falls
 Rich, Mrs. E. L. _____ Sioux Falls
 Sercl, Mrs. W. F. _____ Sioux Falls
 Shreves, Mrs. H. W. _____ Sioux Falls
 Stahmann, Mrs. F. S. _____ Sioux Falls
 Rosenbaum, Mrs. C. L. _____ Sioux Falls
 Stenberg, Mrs. E. S. _____ Sioux Falls
 Stevens, Mrs. G. _____ Sioux Falls
 Stevens, Mrs. R. G. _____ Sioux Falls
 Stern, Mrs. C. A. _____ Sioux Falls
 Unruh, Mrs. B. H. _____ Sioux Falls
 Van Demark, Mrs. R. E. _____ Sioux Falls
 Van Demark, Mrs. W. E. _____ Sioux Falls
 Van Lier, Mrs. P. C. _____ Sioux Falls
 Volin, Mrs. Henri P. _____ Lennox

Volin, Mrs. V. V. _____ Sioux Falls
 Wessman, Mrs. N. E. _____ Sioux Falls
 Wieseler, Mrs. R. J. _____ Sioux Falls
 Green, Mrs. C. D. _____ Canton

DISTRICT #8 — YANKTON

Adams, Mrs. G. S. _____ Yankton
 Auld, Mrs. M. A. _____ Yankton
 Eyres, Mrs. T. E. _____ Vermillion
 Flynn, Mrs. E. _____ Pickstown
 Haas, Mrs. F. W. _____ Yankton
 Hanson, Mrs. H. F. _____ Vermillion
 Hill, Mrs. J. F. _____ Yankton
 Hubner, Mrs. R. F. _____ Yankton
 Klima, Mrs. H. _____ Yankton
 Johnson, Mrs. C. _____ Yankton
 Livingston, Mrs. R. _____ Yankton
 McVay, Mrs. C. B. _____ Yankton
 Ohlmacher, Mrs. J. C. _____ Vermillion
 Ranney, Mrs. B. _____ Yankton
 Reding, Mrs. A. P. _____ Marion
 Sattler, Mrs. T. H. _____ Yankton
 Scales, Mrs. A. B. _____ Pickstown
 Schwartz, Mrs. E. R. _____ Wakonda
 Smith, Mrs. A. J. _____ Yankton
 Steele, Mrs. J. P. _____ Yankton
 Willcockson, Mrs. T. H. _____ Yankton
 Williams, Mrs. D. B. _____ Yankton

DISTRICT #9 — RAPID CITY

Bailey, Mrs. J. D. _____ Rapid City
 Berkman, Mrs. D. S. _____ Rapid City
 Brock, Mrs. E. H. _____ Rapid City
 Davis, Mrs. J. H. _____ Belle Fourche
 Dawley, Mrs. W. A. _____ Rapid City
 Erickson, Mrs. J. _____ Rapid City
 Gieb, Mrs. W. _____ Rapid City
 Grau, Mrs. H. J. _____ Rapid City
 Hare, Mrs. L. _____ Spearfish
 Howe, Mrs. F. S. _____ Deadwood

Holleman, Mrs. W. W. _____ Rapid City
 Jackson, Mrs. A. S. _____ Lead
 Jernstrom, Mrs. R. E. _____ Rapid City
 Kegaries, Mrs. D. L. _____ Rapid City
 Kobza, Mrs. V. _____ Rapid City
 Koren, Mrs. P. _____ Rapid City
 Lampert, Mrs. A. A. _____ Rapid City
 Lemley, Mrs. R. E. _____ Rapid City
 McCroskey, Mrs. R. C. _____ Rapid City
 Merryman, Mrs. M. P. _____ Rapid City
 Meyer, Mrs. W. L. _____ Sanator
 Miller, Mrs. G. H. _____ Spearfish
 Minty, Mrs. F. W. _____ Rapid City
 Newby, Mrs. H. D. _____ Rapid City
 O'Toole, Mrs. T. F. _____ Rapid City
 Owen, Mrs. G. S. _____ Rapid City
 Owen, Mrs. N. T. _____ Rapid City
 Spain, Mrs. M. L. _____ Rapid City
 Williams, Mrs. F. R. _____ Rapid City
 Yackley, Mrs. J. V. _____ Rapid City

DISTRICT #10 — ROSEBUD

Quinn, Mrs. R. J. _____ Burke
DISTRICT #11 — NORTHWEST
 Kalda, Mrs. E. F. _____ Platte
 Lowe, Mrs. C. E. _____ Mobridge
 Steiner, Mrs. T. K. _____ Lemmon
 Totten, Mrs. F. C. _____ Lemmon

**DISTRICT #12
WHETSTONE VALLEY**

Brauer, Mrs. H. H. _____ Sisseton
 Brinkman, Mrs. W. C. _____ Sisseton
 Duncan, Mrs. W. _____ Webster
 Lie, Mrs. D. _____ Webster
 Pfister, Mrs. F. _____ Webster
 Tauber, Mrs. K. S. _____ Milbank
 Younker, Mrs. F. T. _____ Sisseton

Dear Auxiliary Members:

By this time most of you have held your first meeting in your district and are busy getting the year's work organized. I hope that you will find a great deal to interest you in the programs planned and that much can be accomplished this year. There is much good work being done by the Woman's Auxiliary to the American Medical Association and its component auxiliaries over the nation. One has but to read the reports of the State Presidents in the August 1951 issue of the Bulletin to gain a new perspective of the job ahead.

Many of our members have said that they would like to see a state wide project carried on by our Auxiliary. Perhaps we would get a good deal of satisfaction from knowing that we were unified in at least one plan, tho our program does give us this chance, namely, giving our support to the Today's Health and Bulletin.

I have contacted an agency which is gathering medical and surgical supplies for recognized agencies, hospitals, welfare groups and missions overseas with the sole proviso that

the recipients render free medical and dental care to the needy in 29 areas, widely scattered over the world. Paraguay, Austria, Hungary, Korea, Indonesia, Egypt, Israel, Italy, France, Philippines, and the Middle East are but a few.

The Medical and Surgical Relief Committee, Inc. 420 Lexington Ave., N. Y. is unique in that it is the only agency solely engaged in relief thru distribution of medical and surgical supplies. Used medical and surgical instruments in good condition, medicines and drugs, and hospital supplies are on their list of urgently needed materials.

Many of the medical Auxiliaries over the Nation have collected materials for this committee in the past two years. In 1949-50 Michigan collected two and one half tons as one of their projects. The expense of shipping this material to New York must be borne by the Auxiliary as the committee has no funds available for this purpose. They mention that it is sometimes possible to interest some firm who is making a shipment to include the packages or some organization who

will assume the motor or freight charges as a donation to a good cause. Each district could collect and ship just what they felt their budget would allow.

I know that most of us could get unused surgical instruments from our husbands' offices which they no longer use, but would have a long period of usefulness where they are less plentiful. Samples of drugs, samples of baby foods, vitamins, all types and strengths, sedatives, sutures (catgut and silk, iron and liver preparations, hypo needles and syringes are a part of the long list.

The Medical and Surgical Relief Committee has as its President Elect Admiral W. F. Halsey, USN (Ret) with the Honorable Harold E. Stassen as Vice-Chairman. Its Medical Advisory Committee contains the names of Dr. Loyal Davis, Dr. Howard K. Gray, Dr. Howard C. Naffsiger and Dr. Alton Oschner, along with many other recognized doctors. They are "chartered under the laws of New York as a voluntary, charitable Corporation for the purpose of raising and expending funds to be used exclusively for charitable and benevolent causes."

Shipments should be addressed to:

Medical and Surgical Relief Committee,
Inc.

Room 328, Graybar Building
420 Lexington Avenue
New York 17, N. Y.

I am giving you this in the hopes that you will give this serious thought in your districts and I would welcome your comments, as individuals and as groups. If you are interested in taking part in such a project, let me hear from you and if you are not and have a reason for this choice, I still would like your opinion. Of course, I see no reason why a few districts or even one, could not take part in this work even if the state as a whole did not, but I am asking for comments, so may I please hear from you?

ITEMS MOST URGENTLY NEEDED

Anesthetics (General, local)

Anthelemintics

Antibiotics (Aureomycin, Chlormycetin,

Penicillin, Streptomycin, Terramycin)

Antimalarial Agents (Atabrine, Quinine)

Aspirin & Combinations

Baby Cereals & Foods

Dietary Supplements

Disinfectants & Germicides

First Aid Supplies

(Adhesives, Bandages, Gauze etc.)

Hospital Ware

Hot Water Bottles & Syringes

Hypo Needles & Syringes

Iron, Iron & Liver Preparations

Laboratory & Scientific Apparatus

Rubber Sheeting & Tubing

Sedatives (Capsules or Tablets)

Standard Medications(Ampules, Capsules,
Tablets for modern therapy)

Surgeon's Gloves & Needles

Sutures (Catgut or Silk)

The Sulfonamides (All forms)

Thermometers (Fever— F or C)

VITAMINS (All types & strengths)

District Presidents:

If you have not sent a complete list of your officers and committee chairmen to Mrs. Howard R. Wold, 613 N. Washington, Madison, S. D. will you please do so? National is asking for these in order that they be sent material relative to their department, and our state chairmen want them too.

District Public Relations Chairmen:

Did you remember to send an account of your district meeting to the local paper and to your Auxiliary President to be used in the South Dakota Medical Journal on the "Auxiliary Activities" page? Has a new doctor moved into your district? Is there a new baby in your district? We are interested in getting NEWS of each of you.

Did you know that our National Organization Chairman, Mrs. Leo J. Schaefer has asked our immediate past-presidents, Mrs. A. P. Reding of Marion to be co-chairman of the North Central Region? Mrs. Reding is to act as a contact with North and South Dakota, Nebraska and Kansas. Congratulations, Muriel, and . . . South Dakota is represented on a National Committee.

A new chairman for Civil Defense has been added to the National committees, and I have asked Mrs. F. R. Williams of Rapid City to serve as our State Chairman.

District Secretaries:

Have you prepared a list of names and addresses of all living Honorary Members or wives of deceased doctors in your district? If you have, will you send this list to Mrs. A. P. Reding, Marion, S. D. so that these members may receive the NEWSLETTER? Thank you so much!

J. E. BRUNER, M. D.

South Dakota's General Practitioner of the Year



Photo by Aberdeen American News

J. E. Bruner, M.D., Aberdeen, was named South Dakota's General Practitioner of the Year by the Council of the South Dakota State Medical Association at its regular Fall Meeting. Announcement of the award was made public on October 26.

Dr. Bruner is a typical practitioner in the tradition of service to his people. Two years at Hecla, South Dakota, twenty-two at Frederick, and twenty in Aberdeen attest to his interest in the welfare of "his people."

His natural reticence towards publicity made it difficult to secure information on his experiences but with assists from his wife and friends, some information was available.

Dr. Bruner was born in Glidden, Iowa, attended the University of Michigan and Rush Medical College where he graduated in 1904. His South Dakota practice in Helca was begun after three years in Iowa.

His memories include "kitchen table" surgery aided by auto headlights or kerosene lamps, blizzards, mired automobiles, and teams struggling through all sorts of weather. Although he doesn't say so, he probably also remembers with satisfaction the hundreds of new babies, the sick children made well by his ministrations and perhaps the fees that were never collected.

It's been a full life for our General Practitioner of the Year — the physicians of South Dakota congratulate you on your appointment, Dr. Bruner.

The Rationale and Technique of Sex Hormone Replacement in the Aged Female, A Preliminary Result Report

BY WILLIAM H. MASTERS, M.D., ST. LOUIS, MO.

Introduction

The menopause has been accepted by both the medical fraternity and the laity as a period of change during which the average female retires from a reasonably active to a relatively passive existence. The concentrated activities of raising a family are gradually superceded during the decade from 45 to 55 years by the less strenuous demands of spoiling the grandchildren and puttering in the garden. In view of the steady increase in expected longevity, and the gradually widening differentiation between the life expectancy of the female and that of her selected male, it is time we realized that to put a female of 55 on the shelf and leave her there for the next twenty to twenty-five years is a major mistake in our present day thinking.

The science of Gerontology has been aptly defined by one of the leading journals in the field as an attempt to "add life to years, rather than years to life." It is inevitably true that as our facilities and abilities improve for the treatment of disease and medical and surgical emergencies, we are adding years to the lives of our patients. This extra dividend is actually accumulative. It starts with good medical care in infancy, and progresses through the comparatively superior type of medical protection afforded the adult of this country under the stimulation of the individual state medical societies such as yours in South Dakota. It remains for the medical profession to swing the pendulum of concentration toward regeneration of useful mental and physical function in the aged, if we are to provide a more adequately balanced program of medical care for the aged.

There are many reasons for revising our gerontological thinking not the least of which is based on pure financial consideration. We are progressively increasing our indigent aged population. State supported institutions for the housing and care of this rapidly multiplying segment of our society are grossly overcrowded, and as more beds are made available to meet the ever increasing demand, our tax burden becomes progressively heavier. It goes without saying that a basically non-productive segment of society is not only a financial burden to the active population but is a tremendous waste of manpower. Certainly manpower is of particular import in these critical times. What possible value can we contribute to our newer and better surgical techniques and our antibiotic and endocrine therapies as life protecting and saving mechanisms in old age, if we are not to provide an avenue of productive activity for these aged individuals?

It was with these thoughts in mind that basic research in endocrine replacement and subsequent tissue regeneration in the aged female was first instituted by the Division of Gerontology of Washington University School of Medicine in St. Louis. Female patients were chosen for investigative treatment for several reasons. First, a more objective study of target organ results could be obtained in the female than the male. Second, females as a sex constitute more of a public health problem than the males due to their greater expected longevity. Third, they are, as a rule, generally more amenable to therapy, repeated biopsies, and examinations than are the males. And fourth, our female population is generally more static than the male.

The method of sex hormone replacement in the female to avoid the unfortunate results of metabolic imbalances associated with the menopause is well known. Such men as Sevringhaus,¹ Allen,² and Engle³ have re-

* Presented at the S. D. Pharmaceutical Convention held at Watertown, S. D., 1951.

From the Department of Obstetrics and Gynecology, and the Division of Gerontology of the Washington University School of Medicine, Saint Louis, Missouri.

peatedly championed careful, intelligent use of the sex steroids in the 45 to 55 year age group. They have felt that steroid replacement was especially indicated when the menopausal syndrome was in such full sway that the individual female was partially or even completely unable to meet the demands of her partial society.

In basic opposition to these views are those expressed by Gusberg⁴ and Crossen⁵ who attribute possible carcinogenic activity to the sex steroids. Their arguments are based upon two main supports. First, the sure knowledge that unopposed estrogen will produce a hyperplasia of the endometrium if the uterus is under the estrogenic influence for a sufficient length of time. Second, the palpable but unproven assumption that hyperplasia of the endometrium may be a precursor to carcinoma of the endometrium. Certainly the well established animal experimentation work on the carcinogenic effects of estrogens in certain strains of inbred mice predisposed to cancer of the breast⁶ has also been a major plank in the opposition platform. The blunt truth of the matter is that a carcinogenic effect of the sex steroids has not been proved or disproved for the human female at the present writing.

With the pros and cons of steroid replacement therapy fresh in our minds, it was felt that pilot experiments should be instituted in the aged female population with the following thoughts in mind. First, a controlled series of long continued sex steroid replacement was to be of paramount importance. Second, laboratory and autopsy coverage was considered absolutely necessary. Third, unopposed estrogen stimulation (in deference to the well considered opinions expressed above) was to be avoided at all costs.

The St. Louis City Infirmary became the source of patients for replacement therapy. Sufficient personnel and beds were made available to control the administration of medication and provide adequate space and facilities for the long continued care of the research patients. Each year a new group of patients has been started with investigation concentrated toward new phases of tissue reactivation and maintenance. Laboratory and autopsy coverage have been more than adequate. After six years of clinical observation, repeated physical and mental examinations,

biopsies of skin, muscle, bone marrow, and endometrium, exhaustive physiological laboratory checking, and ultimately, early autopsy results, we can maintain unequivocally that those patients under therapy are with few exceptions significantly, and in many instances spectacularly improved both from a physical and mental point of view. It can also be reported that despite six years of effort we haven't as yet the vaguest idea why the patients have made such significant gains in general well being. It is obviously one thing to know from observation and from physical and mental evaluation that patients are improved. It is yet another and far greater problem to prove our results in the laboratory and perhaps to offer satisfactory explanations from the autopsy table for the specific tissue regeneration that is clinically evident. It has been impossible to correlate clinical and laboratory results at this stage of the investigation.

TABLE I

Estrogen Influence Opposition Methods

- 1. Cyclic estrogen exhibition and withdrawal at regular intervals to shed the endometrium.
- 2. Constant estrogen influence with cyclic progesterone exhibition and withdrawal to shed the endometrium.
- 3. Constant estrogen influence with cyclic testosterone exhibition and withdrawal to shed the endometrium.
- 4. Constant estrogen influence and testosterone opposition to such a degree that hyperplasia is avoided and shedding of the endometrium unnecessary.

Methods

The patients chosen for investigative work ranged from 65 to 85 years of age. Bedridden as well as reasonably physically active patients were selected. Diabetics, cardiacs (primarily hypertensives) and advanced arthritics were included in the series. All patients were first subjected to as complete a general physical and laboratory examination as could be devised. With a reasonable baseline established, estrogen (estradiol benzoate)* was administered in cyclic fashion until withdrawal bleeding could be obtained. The patients were then treated by the various methods of therapy listed in Table I. Care was always taken to provide opposition to long range estrogen influence by the techniques described below.

TABLE I

As noted, estrogen in the first method is forced to provide its own opposition to long continued influence by withdrawal at regular

intervals with subsequent development of estrogen withdrawal in the endometrium. Progesterone and testosterone provide their estrogen opposition (when given in sufficient concentration for short periods of time with subsequent sudden withdrawal) by shedding the uterine endometrium. The combination of estrogen and testosterone in concentration sufficient to be mutually antagonistic to each others' influence on the endometrium and to prevent endometrial hyperplasia has also been exhaustively investigated. It is this final type of replacement therapy that offers by all odds the greatest possibilities for future development. Certainly there is little to offer the female of 75 years if we must return to her the nuisance value of vaginal bleeding every four to six weeks in order to accomplish minor reclamation aims. These periodic bleedings were only of major import in a pilot series and should not be construed as the ultimate public health aim of these experiments. The combination then of estrogens and androgens to stimulate regenerative processes without allowing a dominant position to the clinically distressing qualities of either (vaginal bleeding with the estrogens and hirsutism with the androgens) is as far as can be determined at this juncture the path with the greatest possibility.

All patients have been subjected to regularly recurring physical and laboratory checks while under replacement therapy. It should also be noted at this time that in almost all of our experimentations, the sex steroids were administered intramuscularly. The hypodermic route was only the procedure of choice in the pilot experiments. It was of vital necessity to be sure that the patients received exactly what was planned for them. Oral preparations of all the sex hormones are available in most satisfactory concentrations and the oral route is by far the preferable method of dispensing medication, when large scale replacement work is to be considered.

Results

A brief review of clinical improvement obtained is in order at this time. During the better than six years that this work has been in progress, well over one hundred aged women have been treated. Once replacement therapy is instituted it is generally maintained until the death of the patient or the

termination of the particular research project intervenes. Experimental groups have purposely been kept small in total membership because of the original nature of the work, and the obvious need for exhaustive laboratory control.

The original investigative group was started on estrogen replacement until uterine regeneration was obtained in sufficient degree to allow withdrawal bleeding. Once a bleeding dosage of estrogen was established the patients were placed on this constant medication for as long as they would live or we could keep them in the series. The uterine endometrium was then shed regularly with varying dosage levels of progesterone⁷ to avoid endometrial hyperplasia. Of the original fifteen members of the group (ages 67 to 85) eleven were completely bed-ridden for a minimum of two years and in one instance eleven years prior to the onset of therapy. Within two years after therapy was instituted, all members of the first group were ambulatory and able to take personal care of themselves. Some group members even graduated to minor daily duties such as distributing food trays in the wards at mealtimes or helping in the light floor maintenance work.

The original group of fifteen patients now has only three surviving members. During the intervening years the group has been split by several factors. Two patients (both well able to take care of themselves at the outset of the experiment) showed no demonstrable physical or mental improvement and were dropped from the series after three years of therapy. One patient ultimately refused the medication after two years of therapy and was removed from consideration. Three women improved to such a degree over their original bed-fast condition that their families, feeling that they would no longer be a major nursing problem, removed them from the institution over objection. All three reverted to their beds within six months' time without therapy. Six patients have died and autopsy results are now available on four of these individuals. There are still three patients on what amounts to regularly recurring menstrual periods six years after the start of therapy.

Other groups have followed similar patterns of improvement despite wide variation

in types and amounts of dosage and therapy combinations.

A recently completed rigidly controlled series to evaluate psychiatric changes at six months and one year after onset of therapy will soon be published jointly with the Department of Neuropsychiatry of Washington University School of Medicine.

Obviously the major problem of present thinking is no longer concerned with the question of "Are the patients improved under therapy?" The question has been rephrased to read "Why are the patients improved under therapy?" Laboratory control has been a major disappointment as an answer to the rephrased question. With the exception of a gradual rise in the basal metabolic rate and a corresponding reduction of serum cholesterol levels for patients under therapy, there has been no significant trend in laboratory analysis during the six years of work. A detailed report of the laboratory coverage is to be published in the near future.

The autopsy table may well provide the information that has been so intensely sought. Of the six deaths in the experimental group we have been discussing, four patients have undergone complete autopsies. These tissues and the results of eleven more autopsies in other experimental group patients are now undergoing exhaustive investigation. Preliminary results now available present most interesting changes in target organ tissues.

Regeneration of pelvic viscera tissues becomes immediately apparent at gross dissection. The vaginal mucosa is thick and corrugated in appearance. The cervix has hypertrophied from its senile state and the cervical glands are in an active secretory phase. The corpus is enlarged to size compatible with the 20 to 30 year age group, and the endometrial cavities usually measure from two and one-half to three inches in depth. The major exception to the gross regenerative processes in the target organs appears to be the ovaries. They remain small and dull gray-white in appearance. Although there is an obvious increase in blood supply to the hilum of the ovary there is certainly no evidence of follicle stimulation or growth.

Under the microscope major attention is immediately focused on the walls of the smaller blood vessels of both uterus and ovary. The walls of the vessels in these

organs show a strong resurgence of activity in the medial layers. There is also a definite suggestion of vessel recanalization and of reduction of hyalin content in many of the previously thrombosed vessel walls. These startling results are presumably the end result of a great increase in work demand placed upon the vascular system by regeneration and reactivation of the intrinsic tissues of the target organs.

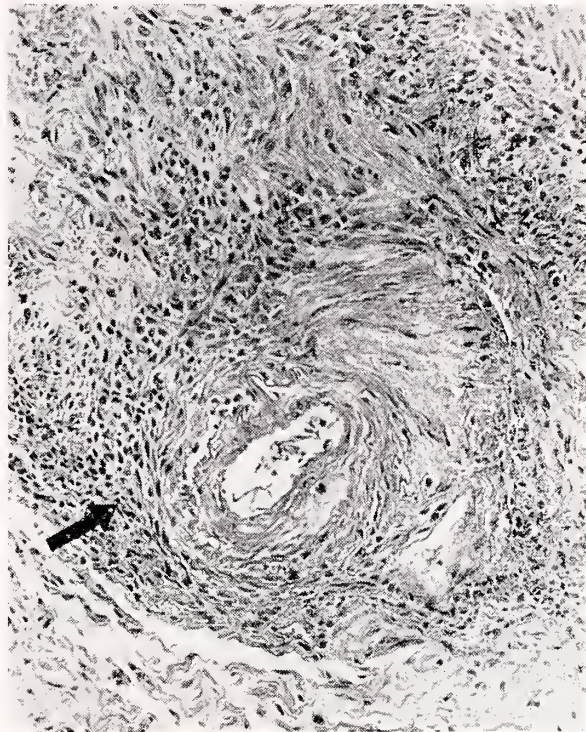


Fig. 1

Age 62—Note hyalinization of vessel walls and lack of medial activity.

Figures 1 and 2 are provided to show briefly the activity in the medial layers of the small blood vessels following long continued therapy. Figure 1 represents a section through the uterine muscularis of a woman 62 years of age who had an apparently normal menopause at 48 years. Notice the lack of medial activity and the advanced degree of hyalinization of vessel walls. Figure 2 shows the autopsy section of an experimental group patient 78 years old, who died after four years of continuous steroid replacement therapy. Notice the completely different picture of medial proliferation and absence of hyalin. This is a representative section taken from a series of serial sections through the uterine wall of this experimental patient.

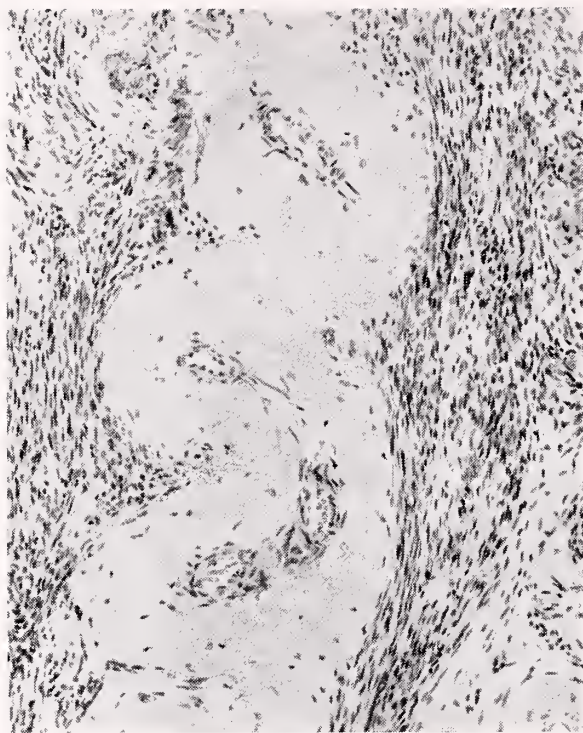


Fig. II

Age 78—Four years of sex steroid replacement therapy—Note minimal hyalin still remaining in vessel wall and marked cellular activity in the media (arrow).

It is obvious that no generalized claim as to results obtained can be made at this time. As stated, this is purely preliminary report. Another ten years of work with gradual accumulation of autopsy and differential laboratory results may confirm tissue changes now only suspected. We must find somewhere the answer to the cause for the obvious clinical improvement of these patients under therapy if we are ever to have anything of major import to offer from a public health reclamation point of view.

SUMMARY

In brief summation, aged female patients have been subjected to sex steroid replace-

ment over a period of years in an attempt to determine possible clinical and laboratory effects of stimulation of the aged in this manner. There is a generalized physical and mental improvement from a clinical point of view in many of the patients under long continued therapy. Occasionally, progress has been made to a startling degree. The workers are to date at a complete loss to explain clinical improvement on the basis of laboratory findings as most laboratory results have been consistently negative. Early autopsy findings suggest important changes in the vessel walls of target organs. Results of studying other body organs are not sufficiently advanced to be available to publication at the present writing.

Only the first steps have been taken. Widespread public health evaluation is necessary before any claims may be made. It is time, however, as our expected longevity increases, that the problems of the aged population become of major moment to all physicians. We must find a way to successfully add "life to years."

BIBLIOGRAPHY

1. Sevringhaus, E. L.: The Management of the Climacteric. Charles C. Thomas, Springfield, Ill., 1948.
2. Allen, W. M.: The Female Sex Hormones. Sharp & Dohme "Seminar" Vol. 8, No. 2, 1946.
3. Buxton, C. L. and Engle, E. T.: The Diagnosis and Therapy of Gynecological Endocrine Disorders. Charles C. Thomas, Springfield, Ill., 1949.
4. Gusberg, S. B.: Precursors of Corpus Carcinoma, Estrogens, and Adenomatous Hyperplasia. *Am. J. Obst. and Gynec.*, 54:905-927, 1947.
5. Crossen, R. J. and Hobbs, J. E.: Relationship of the late Menstruation to Carcinoma of the Corpus Uteri. *J. Missouri M. A.*, 32:361-369, 1935.
6. Strong, L. C.: Establishment of "A" Strain in Inbred Mice. *J. Heredity*, 27:21-34, 1936.
7. Masters, W. H. and Allen, W. M.: Female Sex Hormone Replacement in the Aged Woman. *J. Gerontol.*, 3:183-190, 1948.

ACKNOWLEDGMENT

* All of the sex hormone preparations used in this work for the last six years have been graciously supplied by the Schering Corporation, Bloomfield, New Jersey.

McKennen Clinic

Banthine*

By Robert Ogborn, M.D., Sioux Falls, S. Dak.

Edited by A. K. Myrabo, M.D.

McKennen Hospital

About four years ago, to this same body, I presented a paper discussing what was then thought by some men a new medical treatment for peptic ulcer, as a group entero-gastrone and uro-gastrone. Since then, this has been proved to be a better therapy for dogs than humans and is pretty well in the discard. Today, rather than to present any single case, or group of cases, I thought I would review a relatively new treatment for ulcer, a review paper of a hundred cases and compare them a little with my own cases that I have treated. This group of a hundred cases was reported from North Carolina. Every one of these hundred cases were referred to the surgical service because medical treatment had failed and all hundred of them received banthine therapy. In the nine months of treatment only five ended up with the surgeons. Ninety-five per cent had good results.

Banthine is reported to have a marked spasmolytic effect. It causes a depression of the gastro-intestinal motility, and in a little lesser degree, a reduction of the volume of the gastric contents and in this group from North Carolina a reduction in the acidity. The routine medication was 100 mg. of banthine every six hours. The symptoms abated very shortly. The banthine was raised to 100 mg. every four hours. Everyone of the cases was urged to return to work as quickly as possible and to return to a regular diet as soon as possible. Everyone of the patients that they treated had symptoms of active ulcer at the start of treatment and everyone of them had an ulcer crater and most of them duodenal disfiguration. In this group there were six jejunal ulcers following posterior gastro-enterostomy. One stomal ulcer, following partial gastric resection, two gastric ulcers,

two channel ulcers and the remainder were duodenal ulcers.

The results were excellent. Most of the patients gained weight. Those that were overweight to start with because of their taking a lot of milk and cream could do away with this and they lost weight. The pain of ulcer was almost immediately reduced or stubbed. On their group, they did fluoroscopic examinations and G.I. series from two to three weeks after the start of the treatment, then at six week intervals for two or three times, and at a two to three month interval. Without exception the 95 that didn't go to surgery showed marked improvement. Most of them showed the loss of the crater and many of them showed less disfiguration in the duodenal area. A few did show some more contracture in this area and it was felt that it was due to the healing contraction of the scar.

In studies on the effect of vagotomy, it is indicated that reduction of propulsive gastric peristalsis is most consistent with a change associated with healing of the ulcer, and this study on these hundred cases showed that the same effect was present. Both vagotomy and enterostomy and gastric resection have some risk of mortality and some incidence of recurrence of the ulcer after the operation. Each procedure is associated with post-operative side effects or complications. We now have a medical treatment that will take a hundred of the worst cases, that are all recognized as possible surgical cases and get 95% good results without surgery. I think the treatment of peptic ulcer should be a medical one.

In my own series of cases from July 10, when banthine was first available here, until the present, I have treated 42 cases of peptic ulcer; two of these were jejunal ulcers following a gastro enterostomy. One was a gastric

* Presented at the McKennen Hospital Annual Staff Clinic Meeting, Nov. 29, 1951, Sioux Falls, South Dakota.

ulcer; 39 were duodenal ulcers. Of these 39, two patients were started on treatment when they had active moderately severe hemorrhage. Their hemoglobins were between 7 and 8 and their red count was a little over two million. One of these duodenal ulcers had what we thought a form fruste and after forty-eight hours of suction, was started on banthine. Every patient either continued to work or was returned to work within one week including the form fruste and the two hemorrhages. All except one, this one with the form fruste, were given a muelengracht or put on a general diet immediately with their banthine. No other medications were given, with the exception of the hemorrhages, which were given iron. Without any exception of any of the cases I have treated there has been no recurrence. One patient of this group had a pain that stopped at the end of 24 hours, about 72 hours started up again and we raised the bathine to a 100 mg. every four hours. Since then he has had no pain.

In private practice it's impossible to convince a patient that feels well and that has no symptoms to go up and get a G.I. X-ray series. We can't use this like a group does, where they run in a bunch of X-rays without cost to the patient. The patient has to pay for it and we're forced to go by how the patients feel. The following are reactions that I have found to this drug. About a hundred per cent of the patients complained of a marked dryness of thier mouth. Fortunately as we lower the amount of drug taken, this lessened. About 75% of the patients complained of heart burn and a bitter taste. This can be relieved substantially by taking the tablets with a little bit of milk. About half of the patients for 24 to 48 hours complained of a fullness of their epigastrium, but fortunately this left even though the medications were carried on. Four out of the forty-two patients had diarrhea that lasted five to seven days and then stopped. Eight patients became markedly constipated and this wasn't relieved without some form of catharsis. The only contraindication that I can find in the use of banthine is gastric pretention. Routinely I have started them on 100 mg. of banthine every six hours and carry them usually for two weeks, then I drop it to 50 mg. every six hours and if they have a perrenial ulcer symptoms, I plan to carry them indefinitely

on that. If they have seasonal ulcer symptoms, I stop anywhere from six to eight weeks on treatment and hope that I'll catch their ulcer before the symptoms get bad the next time. Now the Carolina group recommend that a 100 mg. every six hours be carried on over a period of about two or three months, and the 50 mg. every six hours be carried on indefinitely. They carried it for nine months and thought that they should keep on carrying it. Along with these ulcer patients, I treated three patients with a mucous colitis and all three of them had some benefit. Their stools were cut to two or three a day and they were just soft stools. I treated three patients with ulcerative colitis without any benefit either symptomatically or otherwise, but in the number of cases that I've had without being able to recheck radiographically or fluroscopically, going entirely on their symptoms, the way they can eat, etc., it sounds by far the best treatment that we've had. Of all the patients that I've treated, none of them have taken anything else but their banthine.

79 SDSMA MEMBERS NOT NOW AMA MEMBERS

79 physicians, members of the South Dakota State Medical Association, have not maintained membership in the American Medical Association in 1951. Of a total of 438 members this means that 18% are delinquent as of November 1.

From the standpoint of districts the Madison-Brookings District leads the way with only 3.8% left of its paid membership still to come into the AMA. The worst records are compiled in the smaller districts where two or three non-AMA members produces a large percentage figure.

District figures follow:

District	AMA Dues % not paid
Aberdeen #1	13%
Watertown #2	6.2%
Madison-Brookings #3	3.8%
Pierre #4	48%
Huron #5	29.1%
Mitchell #6	20.5%
Sioux Falls #7	17.6%
Yankton #8	17.3%
Black Hills #9	13.8%
Rosebud #10	42.8%
Northwest #11	8.3%
Whetstone Valley #12	33.3%

PRESIDENT'S PAGE

D. A. Gregory, M.D.

NOVEMBER MESSAGE

WORKING TOGETHER FOR MEDICAL BETTERMENT



Because of A. M. A. opposition to socialized medicine, it has been accused of failure to cooperate with the Red Cross in its blood procurement program. Our secretary's letter of October, 4th with its commendations from Dr. David N. W. Grant, Director of National Blood program refutes this charge effectively. We are 100% back of this great endeavor of the American Red Cross in collecting blood for the Armed Services. We hope that when you visit Minneapolis you will visit the Collection Center at 1805 Lyndale Avenue, South, which is our nearest bank and donate some blood. It may save a life.

Some think that transfusions are used too often in our hospitals reducing unnecessarily the available supply for the armed services. Blood banks have made our death rate lower than in any previous conflict; but, of course, our aim is to save every life that blood transfusions can save. Dr. Henderson's report on his visit to the Korean front, and through the hospitals there, makes us feel the power of this blood support. It makes us proud too of the devoted service of our M.D.'s. I wonder if Oscar Ewing could have improved it.

That first article on "Responsibility of the Surgeon to Modern Society," in the October, 6th issue of the J.A.M.A., is interesting and gives food for thought. It should be read by all members of our ancient and honorable profession.

Professional journals have a certain amount of highly scientific and uninteresting articles in them, because it is difficult for the editors to obtain accurate scientific articles which are tersely and interestingly presented. There is a good opening for the skilled medical writers. I think all authors of medical papers should read the condensations that appear in Modern Medicine now under the editorship of Dr. Alvarez. These articles contain more meat and less padding than any other professional journal.

Speaking of working together and thinking of professional improvement reminds me that one of my duties, as your president, is to visit the component societies. If the district secretaries will send notices of their meetings to John Foster or to me, we will try to visit every district in the state. Please give us two weeks notice if possible. I said visit not inspect or lecture. We feel that each unit has something to contribute to the larger unit of which it is a part. As for the talks, I limit mine to two minutes. Instead of talking as the young preacher who was told that "all souls are saved in the first twenty minutes" (by the preacher) — I'll leave 18 for your co-operative effort!

The districts that are not active can visit and attend the scientific meetings of other districts. We can have a more powerful and better educated medical profession in this way. You men practicing are the medical society and the officers are only your servants.

Again let me urge you to give some blood for the armed services and tell your patients and friends to do so; the need is great. Keep remembering that South Dakota Medical School Endowment fund! These re-inforcements are our responsibility.

EDITORIAL PAGE

LONGEVITY — EWING'S PRIDE

An October 19, press release from the Public Health Service of the Federal Security Agency quotes F. S. A. Administrator Oscar Ewing as follows:

"Average length of life in the United States has increased to a record high of nearly 68 years.

The new figure, based on final 1949 vital statistics compiled by the Public Health Service, shows a gain of almost half a year over the average lifetime indicated by 1948 death rates."

Mr. Ewing is naturally pleased by this record, at least that's what we read into his release. He mentions, too, that this average increase is largely due to the control of infectious diseases.

Nowhere in his message does he attribute any credit to the medical profession, the medical researchers, and the pharmaceutical manufacturers. We wonder if Mr. Ewing is loath to admit that the medical and allied professions have accomplished anything in maintaining life?

We can see in this news release one of the best arguments for the uncontrolled practice of medicine. Truly — it does give the United States the best medical care available in the world today.

Oh yes — We can remember when public health news releases were made by the doctor of medicine in charge of the Public Health Service. Let's see now, what is his name?

GULLIBLE'S TRAVELS

Thursday Sept. 27 — After three consecutive days in the office, I traveled ten blocks to attend a meeting of the Board of Directors of the Minnehaha County Mental Health Center, who are looking for a Psychiatrist with little success.

The next morning, I rolled out early to attend a breakfast at the Cataract Hotel to hear **Lee Price**, national Junior Chamber of Commerce president, give a talk. Later, I visited briefly in my office with **Dr. Gregory**, association president.

More office doings until Wednesday, October 3 when I drove to Yankton to attend the District meeting at Sacred Heart Hospital. They had a very fine meeting with an excellent attendance.

The following Wednesday, I attended a meeting of the Board of Directors of the South Dakota Mental Health Association at 9:00 A. M. at the Carpenter Hotel. Did a brief tape recording on mental health for broadcast on a KSOO news period and then met with **Drs. H. E. Davidson** and **V. V. Volin** who form two-thirds of the Medical Association Mental Health Committee.

With **Dr. Guy Van Demark**, I drove to Huron on the 14th to attend a meeting of the Advisory Committee to Selective Service and the medical subcommittee.

Wednesday evening, the 17th, I spoke at a combined meeting of labor union auxiliary members in the Sioux Falls Labor Temple.

On the 19th, I drove to Vermillion with Mrs. Olga Ulberg, president of the State Nurses Association to pay last respects to Mrs. Don Slaughter who had passed away two days before.

Tuesday, October 23 — attended a luncheon sponsored by the Republican Central Committee, to hear **Senator Taft** speak. Renewed acquaintances with Senators **Mundt** and **Case** and Congressman **Lovre**. Also met Congressman **E. Y. Berry** for the first time.

EDITORIAL

Your Secretary-Treasurer had a most delightful visit to the Medical Society of the State of Wisconsin early in October. With Mrs. Pankow I made a lieisurely journey thru Southern Minnesota and across Wisconsin. No doubt some of my love for the land of Wisconsin stems from the fact that it is the state of my Father's birth. Surely the spirit of pioneerism must have been great to have drawn that hardy soul from such a beautiful country to the then rough and uncouth land of the Sioux.

The scenery and delightful highways gradually gave way to no less inspiring sights as we approached that impressive and orderly

City, Milwaukee. Altho I have been in Milwaukee on several previous occasions I am never prepared for the friendliness and hospitality that envelopes one entering that City. For a population as great as is Milwaukee's, the business section of the down-town district is not as overwhelming as might be supposed. It was no difficulty whatever to see from afar the high sign on the Schroeder Hotel where the Society had reserved rooms for us, and from the time we drove up to the entrance until we left we were made to feel that the Hotel, the City and the Wisconsin Medical Society were just unexpressably happy to have us their guests.

On Sunday afternoon I attended the meeting of the House of Delegates. Charley Crownhart, the Executive Secretary, Drs. H. H. Christofferson, A. H. Heidner, R. L. MacCornack, Steve Gavin, and so many others seemed to conspire to make me feel like one of the gang. They succeeded admirably, and my greatest difficulty all during the several sessions that I attended, was to remember that I was just a guest and not one of the delegates, and to keep my big mouth shut, and my EARS open.

In many ways the sessions were familiar. The same type of committees gave the same type of reports that were sent to the same type of reference committees. It was very obvious that their Committees had been working, too, and that good committee work and reports is not peculiar to South Dakota.

There are several refinements that I should like to pass on to our own organization. Their standing committees meet at a scheduled time and place where they listen to arguments from any member who cares to appear before them for or against any matter before that committee. This serves to get much of the argument off the floor of the House, and by the time that the committee report finally gets back to the House of Delegates, the Reference Committees have a pretty good idea of the wishes of the Society, and their recommendations are then usually passed with almost no discussion from the floor. This makes possible that interested persons can get their arguments across and listen to counter arguments in the informal atmosphere of a committee room instead of taking up the time of the entire House of Delegates with unnecessary bombast and debate. It also pre-

vents highhanded disposition of a report by a hand-picked committee of any oligarchy.

After each session of the House of Delegates, I was a guest at the regular buffet meals served their Delegates and Officers. At these and at the Preprandial Hour before the Banquet, I was most happy to be able to find some of my class-and school-mates who had located in various parts of Wisconsin. More than one of them have risen to high positions in the Society and esteem in their localities. This did not surprise me because they were such men as were obvious leaders even in their school days when I knew them better. It was pleasing to find that their early promise had been fulfilled.

Wisconsin numbers its membership in thousands to our hundreds. The trend of their policies impresses me as a bit more liberal or leftist than ours, but it is so possible that they may be right and ahead of us in their thinking and handling of the problems of the care of the low income groups. Altho there was a definite division of opinion as to the service indemnity fees of the "Blue Shield" plan adopted, their reports and work show great thought and possibly a proper solution. As yet, I personally prefer a cash indemnity plan of prepayment coverage. It is very probable, however, that a plan such as theirs will work better in a highly industrialized State than it would in ours.

No words of mine can express the worth, to me, of the interstate good-will that this visit created for me. I hope that I may have, to some small measure, created a not too unfavorable impression of our State Association on those with whom I visited and exchanged ideas. I urge all doctors interested in the National welfare of our Profession, to avail themselves of every opportunity to visit every State Meeting possible. You will find that their problems are similar to our own, and that they may have ideas on some of them that will be most helpful to us in solving them together.

L. J. Pankow, M.D.

USING THE STOCK MARKET TO "KEEP EVEN" WITH INFLATION

Twenty years ago there was the story of the millionaire who offered half his fortune to anyone who would, in turn, guarantee the

(Continued on Page 313)

This is



NOVEMBER
1951
Vol. 4 No. 11

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Senators Mundt and Case Back Medical Men's Views

Action on S 337 which provided Federal grants to medical schools was recommitted to committee after a standing vote which virtually puts the bill out of existence this session. An amendment which reduced payments to schools individually but increased them when additional students over the previous average enrollment, was defeated in a roll call vote. Both Senators Mundt and Case voted against the amendment. Capitol observers feel that if this amendment had not been defeated, the bill itself might have received a favorable vote. Later, in a voice vote, the bill was recommitted to committee.

In another action, Sen. Ecton of Montana introduced an amendment to allow all medical expenses as deductible items for income tax purposes rather than just the amount over 5% of the income as it now is. In the discussion from the floor, Senator Case presented arguments in favor of the Amendment which was also favored by most doctors in the country.

Although the amendment

was rejected, the attention of all South Dakota physicians is directed to the active support lent by Senator Case.

ABERDEEN DISTRICT SCHEDULES SPEAKERS

Laying plans for a full season of medical meetings, the Aberdeen District Medical Society has scheduled speakers through May of 1952.

Already appearing before the group have been Dr. C. H. Schiefley, Rochester, on "Unusual Aspects of Coronary Disease"; Dr. John B. Gross, Rochester, on "Chronic Relapsing Pancreatitis" and Dr. N. K. Jensen, Minneapolis, on "Crushing Injuries of the Chest."

Meetings scheduled to follow will feature Dr. Horace G. Scott, Minneapolis, on "Treatment of Varicose Veins" (Dec. 5); Dr. S. L. Aray, Minneapolis, on "Infant Feeding" (Jan. 2); Dr. Ray F. Cochrane, Minneapolis, on "Vaginal Bleeding in Relation to Ob. & Gyn." (Feb. 6); Cancer Symposium (Mar. 5); Dr. Richard McGraw, Minneapolis, on "Psychosomatic Medicine" (April 2) and Dr. Robert W. Cranston, Min-

neapolis, on "Common Neurological Disorders."

A general invitation to attend has been extended to all medical association members who may be in the vicinity at the time of these meetings. They are held in the evening at the Sherman Hotel.

UROLOGY GROUP SPONSORS ESSAYS

The American Urological Association offers an annual award of \$1,000.00 (first prize of \$500.00, second prize \$300.00 and third prize \$200.00) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Chalfonte-Haddon Hall, Atlantic City, New Jersey, June 23-26, 1952.

For full particulars write the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, New Jersey. Essays must be in his hands before February 15, 1952.

Nearly 83% of S.D. Doctors Are Association Paid Members

In a survey of paid memberships in the South Dakota State Medical Association it was learned that 82.7% of the eligible physicians in the State were paid up members as of October 15, 1951. This is based on 529 eligible physicians (includes 38 not licensed because of Federal service, etc.) and 438 paid or honorary members.

Best record of memberships belongs to District 11 (Northwest) which has a 100% of those eligible. Next best percentage is that of 96 held by the Huron District 5. They are waiting for one additional member to make their record perfect.

Lowest percentage is held by Whetstone Valley District #12 with 72.2 followed by the Black Hills District with an even 75%. In actual numbers, the Black Hills has the greatest number of non-members or delinquent members with a total of 24.

Of the 91 non-members or delinquent members 9 have not paid 1951 dues although they have been regular members in past years. Five are not considered eligible by the local societies. 26 have not joined because they are over the age for becoming honorary members but cannot meet the requirements for honorary memberships. Most of these are retired or in partial practice.

There are 9 who are not yet members due to the one year waiting period requirement of the Seventh District. It is presumed that all of

these men will be members as soon as they have met the waiting requirement. There are 18 recent licensees who will undoubtedly become members in 1952.

This leaves just twenty four physicians in the State who are eligible but either do not choose to be members or have not been properly contacted.

A rundown on doctors practicing in each district with the number of members and percentages follow:

	No. Practicing	Members	Pct. Members
Aberdeen Dist. #1	53	46	86.8%
Watertown Dist. #2	36	32	88.8%
Brookings-Madison Dist. #3	33	26	78.9%
Pierre Dist. #4	29	25	86.2%
Huron Dist. #5	25	24	96%
Mitchell Dist. #6	40	34	85%
Sioux Falls Dist. #7	119	102	84.8%
Yankton Dist. #8	58	46	79.3%
Black Hills Dist. #9	96	72	75%
Rosebud Dist. #10	10	8	80%
Northwest Dist. #11	12	12	100%
Whetstone Valley Dist. #12	18	13	72.2%
Totals	529	440	83.2%

GOVERNOR APPOINTS ASSOCIATION MEN TO YOUTH COMMITTEE

Governor Sigurd Anderson completed his appointments to the Governor's Committee on Children and Youth by naming **Dr. I. D. Weeks**, president of the University of South Dakota as chairman to replace Judge Rudolph of Pierre.

Appointed along with Dr. Weeks were two representatives of the South Dakota State Medical Association, **Dr. Faris Pfister** of Webster, and executive-secretary **John C. Foster**.

NEWS NOTES

By resolution, the Sioux-

land Medical Association, a group of physicians and allied professional persons who have been sponsoring a radio series on WNAX, Yankton, have renamed the organization, the Siouxland Professional Association.

* * *

Charles Roberts, M.D. has located at Lake Preston. Doctor Roberts formerly practiced in Oklahoma.

* * *

The Yankton District took in three new members at its regular meeting October 3. Coming into the society were **Doctors John Tidd, Maxwell Liebert, and Maynard Porter**.

* * *

Dr. R. B. Fleegeer, Lead, has retired as chief surgeon for the Homestake Mining Company. He is succeeded by **Doctor N. Wells Stewart**. Dr. Fleegeer will continue as a consultant and parttime surgeon for the company.

* * *

Dr. A. M. Semones of Lead has been named president of the North Black Hills Little Theater.

* * *

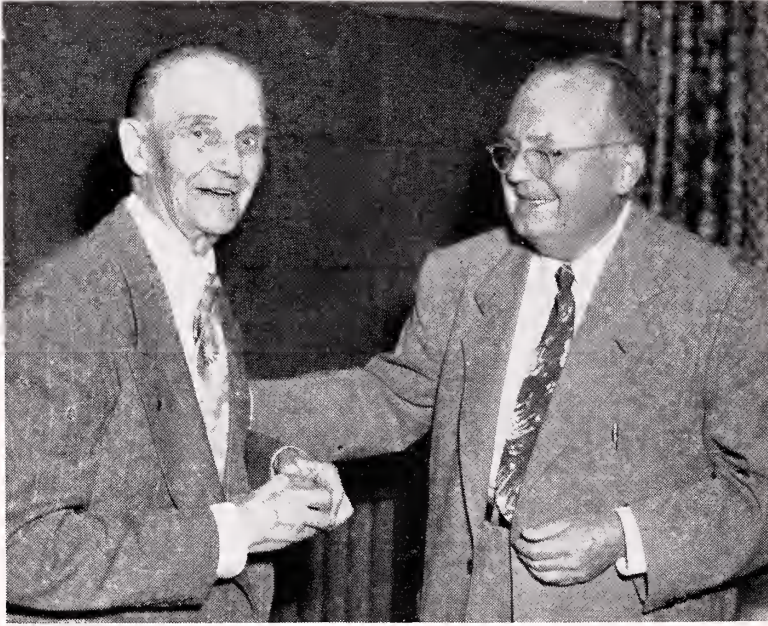
H. E. Davidson, M.D., Lead, was one of the major speakers at the South Dakota Mental Health Association meeting in Sioux Falls, October 10.

* * *

Dr. Robert Van Demark spent a week in October in New York City attending a post graduate course in recent developments in spinal surgery.

* * *

C. M. Kershner, M.D., Brookings, attended the American Academy of Ophthalmology and Otolaryngology in Chicago during the week of October 14th.



ASSOCIATION PRESIDENT GREGORY (RIGHT) PINS FIFTY YEAR AWARD ON DR. A. H. CHRISTENSEN OF CLARK

The Watertown District Medical Society honored one of its older members at the regular meeting of the group on October 2. Dr. D. A. Gregory presented the S. D. State Medical Association's gold pin for fifty years of practice to Dr. A. H. Christensen of Clark.

Dr. Christensen took his premedical work at Valparaiso University in Indiana and graduated in medicine from the Chicago Medical College. He interned at Silver Cross Hospital in Joliet Illinois and practiced there for six years before moving to Clark. He has practiced in Clark for 45 years and was recently honored at a community celebration for those years of service.

Dr. Christensen is the eleventh member of the South Dakota State Medical Association to receive membership in the 50-Year Club.

Others to receive the award are Doctors S. M. Hohf,

Yankton; F. W. Freyberg, Mitchell; W. D. Farrell, Aberdeen; T. J. Wood, Huron; F. L. Class, Huron; O. R. Wright, Huron; H. L. Saylor, Huron; J. W. Stewart, Spearfish; L. J. Townsend, Belle Fourche; G. H. Miller, Spearfish; and F. A. Richards of Sturgis.

TAFT TELLS VIEWS ON HEALTH INSURANCE

Senator Robert A. Taft, announced candidate for the Republican nomination to the presidency in 1952, met with members of the press during his visit to Sioux Falls on October 23.

When asked for his views on compulsory health insurance by assistant editor Dorothy Weck, Senator Taft said, "I vitally oppose compulsory health insurance which would also be termed socialized medicine. I am sure the doctors in particular would find it most unsatis-

factory. I will do the most I can to fight it."

Senator Taft referred to the "socialized medicine" proposals in an earlier appearance before Republican Party workers, stating that all such schemes would tend to socialize our economy to the point where there would be no turning back.

Harold Stassen, who was in South Dakota earlier in the year, made virtually the same statements before large crowds at the Huron fairgrounds.

PEDIATRICIANS MEET IN TORONTO

The American Academy of Pediatrics met for their twentieth annual meeting at the Royal York Hotel in Toronto, Ontario from Oct. 20th to 25th.

Attending from South Dakota were State Chairman, **Dr. Goldie Zimmermann**, **Dr. W. E. Donahoe** of Sioux Falls, and **J. D. Bailey** of Rapid City. Dr. Bailey was accepted as a new member of the Academy.

Featured on the program was a panel discussion on Pediatric Education which included a pediatric practitioner, pediatric surgeon, the president of the American Board of Pediatrics, the Dean of the Pennsylvania Medical School, pediatric psychiatrist, a professor of Pediatrics, and a fourth year medical student.

Other presentations featured discussions of "Neurological Condition in Children" and a symposium on "Carbohydrate Metabolism." An outstanding symposium was presented on "ACTH,

Cortisone and Allied Substances." Papers were presented by J. W. Conn, M.D., U. of Michigan; Lawson Wilkins, M.D., Johns-Hopkins; Joseph Johnston, M.D., Henry Ford Hospital; William Silverman, M.D., Cornell; R. L. Day, M.D., Memorial Hospital, N. Y.; H. L. Barnett, M.D., N.Y.U.; Jerome Glaser, M.D., Rochester U.; and J. D. Keith, M.D., Toronto.

Over 1,600 pediatricians attended the meetings which saw the election of Dr. Warren W. Quillian to the Academy presidency.

MENTAL HEALTH GROUP MEETS IN SIOUX FALLS

The five year old South Dakota Mental Health Association held its Annual meeting in Sioux Falls on October 10. Meetings in the morning session revolved around business matters which included a report on fund-raising activities and four suggested amendments to the by-laws. The Board of Directors met at 9:00 A.M. and the general business session was held at 10:30 A.M.

The afternoon session consisted of seven papers in the field of mental health. On the program were **W. Marvin Larson** speaking on "Progress of Sioux Falls Mental Health Clinic"; **H. E. Davidson, M.D.**, "A General Practitioner Views Mental Health"; **Florence Dunn**, "Mental Hygiene in a Day's Work"; **Rev. Dean Walters**, "Institutional Service Unit"; **Rev. Arnold Herbst**, "Pastoral Counseling for Mental Health" and Miss Katherine

MacMillan, "Affiliate Nursing Program at Yankton."

The banquet speaker was **Dr. Roger Howell** of the University of Minnesota who used as his topic "The Value of the Mental Health Clinic to the Community."

OB-GYN DOCTORS FORM ACADEMY

The National Federation of Obstetric-Gynecologic Societies has reconstituted itself as The American Academy of Obstetrics and Gynecology. This action was taken at the Federation meeting held on June 13, 1951 in Atlantic City in response to the long-felt need for a national society for obstetricians and gynecologists based on individual and personal membership.

The Academy was incorporated on August 4, 1951 as a non-profit corporation under the laws of the State of Illinois. Its objects are listed in the Constitution and By-Laws which were adopted at a meeting held at Hot Springs, Virginia, on September 5, 1951. They include "fostering and stimulating interest in obstetrics and gynecology and all aspects of the work for the welfare of women which properly come within the scope of obstetrics and gynecology."

The first business meeting of the Academy will be held at the time of the meeting of the American Congress on Obstetrics and Gynecology in Cincinnati, March 31 through April 4, 1952. The First Annual Clinical Meeting will be held in Chicago, Illinois, during the winter of 1952-53.

NORTH CENTRAL CONFERENCE HELD NOVEMBER 11

The annual meeting of the North Central Medical Conference was held in Minneapolis, Sunday, November 11. Delegates from South Dakota, North Dakota, Minnesota, Iowa, Nebraska, and Wisconsin represented their state medical associations at the affair which holds its subject matter to medical economic subjects.

Many of the delegates attended the Minnesota-Indiana game on the 10th and then were the guests of the Minnesota State Medical Association at a buffet dinner.

Most of the officers of the South Dakota State Medical Association were in attendance.

NEW COMMISSION ACCREDITS HOSPITALS

The American Medical Association has announced the establishment of a joint commission representing the American Medical Association, the American Hospital Association, the American College of Surgeons and the American College of Physicians for the accreditation of hospitals in the United States and possibly Canada.

The joint commission will be composed of 18 members: six appointed by the American Medical Association, six by the American Hospital Association, three by the American College of Surgeons and three by the American College of Physicians.

While the plan for establishment of the joint commission has already been ap-

proved by the four organizations, none of the 18 members have yet been selected. They will be appointed within a short time. The commission hopes to be in operation by January, 1, 1952.

NEW YORK IS SITE OF AMA TV MEET

On October 16, representatives of medical groups and the television industry met in New York at the Biltmore Hotel to discuss the use of television in health education.

The morning session headed by Dr. W. W. Bauer, Bureau of Health Education, AMA, took as its subject "Building The Health Education Broadcast." Discussing the various phases of the topic were Bauer, Thomas Coffin, NBC TV; Leo Brown, AMA public relations; Roy Marshall, WFIL Philadelphia; and Erik Barnauw, Columbia University Press.

An open forum was held in the afternoon featuring a panel of ten medical educators and TV authorities.

The South Dakota State Medical Association was not represented at the conference because the field of TV has not yet been developed in this area.

NORTH CENTRAL MEET HOLDS FORUM ON HUMAN RELATIONS

Human relations equals public relations was the theme of the North Central Medical Conference held at the Radisson Hotel in Minneapolis on November 11.

President **Fred Sternagel**, M.D., West Des Moines, Iowa, called the meeting to order

and used as the subject of his presidential address, "What Price Security."

He then introduced members of the Forum who discussed personnel in the doctor's office, the doctor's responsibility to his patient, interpretation of medical care costs, and mutual understanding of finances.

The afternoon session took up activities of the AMA, legislative outlook, pre-paid medical care plan and grievance committee.

WOMEN'S AUXILIARY FORMED TO INTER- NATIONAL COLLEGE OF SURGEONS

Formation of a new Women's Auxiliary was announced today by the United States Chapter of the International College of Surgeons.

The Auxiliary functioned for the first time at the 16th annual assembly of the United States and Canadian chapters of the College in the Palmer House, Chicago, September 10 to 13 inclusive. Leading surgeons from every major country of the world outside the "iron curtain" attended the session and convocation.

First officers of the new organization are:

President, Mrs. Custis Lee Hall, Washington, D. C.; first vice-president, Mrs. Horace E. Ayers, New York City; second vice-president, Mrs. Paul W. Craig, Reading, Pa.; third vice-president, Mrs. David Thomas, Lockhaven, Pa.; constitutional secretary, Mrs. Paul M. Egel, Chicago; executive secretary, Mrs. Donald L. Dickerson, Danville, Ill.

Directors are: Mrs. Herbert Acuff of Knoxville, Tenn., Mrs. Gilbert F. Douglas of Birmingham, Ala., Mrs. Elmer L. Henderson of Louisville, Ky., Mrs. William C. MacCarty and Mrs. Henry W. Meyerding of Rochester, Minn., Mrs. Rudolph Nissen of New York City, Mrs. Louis F. Plazak of Berwyn, Ill., Mrs. Max Thorek and Mrs. James T. Case of Chicago, Mrs. Chester W. Trowbridge of Oak Park, Ill., Mrs. William W. Babcock of Philadelphia, Pa. and Mrs. Andre Crotti of Columbus, O.

OKLAHOMA SCHOOL ANNOUNCES P.G. COURSES

The University of Oklahoma School of Medicine has announced postgraduate courses for the year 1951-52.

Included in the schedule is one on General Pediatrics, December 12th, 13th and 14th; Laboratory Examination in Clinical Diagnosis, January 28th through February 2nd; Practical Psychiatry, February 25th and 26th; Electrocardiography, March 3rd through 8th; Review of General Surgery and Surgical Technique, March 11th through May 13th, and X-Ray Diagnosis, May 2nd and 3rd.

HURON DISTRICT HEARS SPEAKER

At its regular meeting on October 12, the Huron District Medical Society heard Dr. Harry Gardner of Glasgow, Scotland who spoke on "Socialized Medicine" as he saw it in his home country.

PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor

Medical Costs As Applied to Pharmaceuticals

by Dr. T. W. Reul, Watertown, S. D.

I come before this group well coached by the local pharmacists with instructions to show that it costs considerably less to recover from an illness today than it did fifteen years ago. This is so in spite of increased medical fees, more extensive laboratory investigation, more expensive pharmaceuticals, and increased hospital costs. Specific and effective medicinal measures, coupled with an accurate diagnosis, has resulted in a decreased period of disability, far fewer hospital days, and many more uncomplicated recoveries.

When one compares present day medical practice with the medical practice of my interne days in 1937, one is astounded at the radical changes which have occurred. Prior to 1937, much advance was made in controlling the acute infectious diseases through public health sanitary measures and rigorous programs of prophylaxis. The physician, however, found himself continually confronted with stubborn infectious disease processes with precision toward a disabling, or frequently fatal conclusion. He felt helpless. First was the diagnosis; then the outlook or prognosis; treatment was meager and well flavored with philosophy, designed to comfort both patient and family.

The ruptured appendix either developed into a generalized peritonitis with rapid exitus or localized itself to the right lower part of the abdomen. If localization occurred, the patient, after surgical drainage of the abscess, was ultimately discharged from the hospital chronically ill and hopelessly undernourished. Recovery was slow; and the danger of further intra-abdominal complications quite prominent.

The trivial throat infection often developed into a resistant middle ear infection with

mastoiditis and fatal meningitis. Then came Sulfanilamide in 1937; Prontisil, Neoprontisil, and Sulfapyridine before 1940; Sulfathiazole and Sulfadiazine, 1940 to 1942; penicillin, 1943-1944; and finally, Streptomycin, Aureomycin, Terramycin, Bacitracin, and Chloromycetin. At present, with the exception of a few virus diseases (none of which are important in our over-all mortality) the physician can control the majority of bacterial, viral, and rickettsial diseases.

The eradication of these infectious diseases by our present therapeutic agents definitely limits the amount of medical attention, shortens or does away with hospital care, and reduces disability to a minimum. By this mechanism, the cost to the patient is not cut, but rather it is slashed.

In 1920, at the Municipal Contagious Disease Hospital in the City of Chicago, 1901 patients were admitted with a diagnosis of diphtheria, with 109 deaths. In 1948, there were but nine admissions and no deaths. In 1938 there were 2,697 scarlet fever cases admitted with 27 deaths. In 1948, there were but 249 admissions with no deaths. The scarlet fever of 1938 disabled rather than killed. Chronic suppurative sinusitis, draining ears, mastoids, and draining glands of the neck were common. Occasionally a child would develop bronchopneumonia, endocarditis, and meningitis. Rheumatoid arthritis and Bright's Disease were not uncommon. It was a pity to see those chronically ill children, compelled to remain in the hospital week after week and month after month. Then, on discharge, they were so disabled as to require many months more of medical treatment, which again had little to offer in the way of therapeutics. The same story is true of meningitis, and many of the other acute infectious diseases. Who, after this, could assail the antibiotic drugs as expensive?

* Given before the Aberdeen District Medical Society at Aberdeen, South Dakota, on November 29, 1950.

When I was a senior medical student in 1936, the mortality rate of pneumonia varied from thirty to fifty percent, depending on the type of epidemic. Failure of resolution, lung abscess, empyema (pleural abscess), and blood stream infections were common. Some cleared readily with only symptomatic measures. Some died quickly of profound toxemia. Some lingered long in the hospital, developing one complication after another. One to three months hospitalization was not uncommon. With the hospital cost, the attending physician's fees, the consultant's fee, and the charge for medications, the total bill might well range from \$1,000.00 to \$1,500.00. Now, the overall mortality for pneumonia varies from five to two percent. Complications are rare. Hospitalization varies from 2 days to 30 days.

Last year an elderly gentlemen of sixty-three reported to the office with a severe right lower lobe pneumonia. He refused hospitalization and elected home treatment. For his original physical examination, laboratory work, and chest X-ray, he was charged twenty dollars. He was given 400,000 units of Procaine penicillin and grams 1 of Streptomycin for seven consecutive days at home, at a cost of forty-two dollars. At a local pharmacy, he received twenty-eight 250 mgm. Aureomycin capsules and sixteen apc capsules with codiene gr. ss for exactly \$17.95. A check examination at the office twelve days after the onset, with laboratory work and chest X-ray, for \$20.00. Recovery was complete and uncomplicated. The cost, a mere \$99.95. Compare this to \$1,000.00 or \$1,500.00 of a few years ago.

Office and home treatment of an uncomplicated severe streptococcus sore throat can be accomplished now in many cases for about \$30.00 or even less. This allows \$5.00 for the original physical examination, \$5.00 for original laboratory work, \$9.00 for injectable antibiotics, and \$11.00 for medications purchased at the pharmacy. This is without any dread complications or hospitalization.

In 1936, the hospital wards contained a goodly number of patients with bone infections (osteomyelitis). This is now a rarity. In 1936, suppurative arthritis was not uncommon, and now it is very rare. In 1936, a simple appendix was kept in the hospital from fourteen to sixteen days, as compared to four days at present. A simple gall bladder pa-

tient was kept two to three weeks as compared to five days at present. A toxic thyroid was slowly controlled with radiation, sedation, and iodine; when surgically treated, it was only fear of the so-called "Thyroid Storm." Now, the anti-thyroid drugs frequently make surgery unnecessary or safe, if performed. In 1936, we were without the antihistaminics, ACTH, and Cortisone; the control of allergies was slow, ineffectual and unimpressive. In 1936, the treatment of venereal infections was so cumbersome and ineffectual that patient cooperation did not permit completion of treatment. At present, control and cure develop before patient exhaustion sets in. The introduction of B. A. L. is helpful in heavy metal poisoning when it occurs.

In 1936, the lack of potent digitalis preparations, non-toxic mercurial diuretics, and antibiotics, made the care of heart patients difficult. Recently, the anticoagulants have proven to be a worthwhile adjunct—Heparin, Dicoumarol, and possibly Alpha Tocopherol.

In addition to the aforementioned pharmaceutical advances, one should at least enumerate some of the other important preparations which definitely lower the patient costs by affording effective and more rapid therapy: Choline and Methionine, Concentrated Liver Extracts fortified with B 12 and folic acid, Non-toxic Antispasmodics, Potent Hormones, Atabrine, Chloroquine Diphosphate, Disoxycorticosterone Acetate, Dramamine, and Prastigmine.

One could go on at great length listing examples such as I have. But, what does it all mean? Drug therapy, as developed these last fifteen years, has brought effective control for the medical and surgical management of patients directly into the hands of the general practitioner. He, in turn, has been able to obtain splendid results with a minimum of disability and expense for the patient. He is able to employ surgical procedures which could not have been attempted by any other than a specialist fifteen years ago. When consultation is necessary, it is obtained; and, frequently, definite treatment can be accomplished well by the family doctor.

Hence, anyone who now complains as to the high cost of pharmaceuticals should be pleasantly reminded by the pharmacist of the situation fifteen years ago.

LOCAL DRUGGISTS HONORED AT RAPID CITY PHARMACY SOCIETY MEETING

The regular monthly meeting of the Rapid City Pharmacy Society was held Tuesday night, October 2nd, at the Alex Johnson Hotel with wives and husbands of members present. Organ music was presented by Miss Dorothy Kubler of Deadwood throughout the evening.

M. C. Beckers was presented with a gold lined mortar and pestle in appreciation of his nine years of service as a member of the South Dakota State Board of Pharmacy.

Harold Mills was congratulated on his recent appointment by Governor Sigurd Anderson to the State Board of Pharmacy to fill the vacancy left by Mr. Beckers. Best wishes were extended to Mr. Mills.

Fred Eikhoff of Beckers Drug was honored by being presented with a War Savings Bond by his employer, Mr. Beckers, for being the longest employed registered pharmacist in one store in Rapid City.

NEWS NOTES

The S. D. Board of Pharmacy and Executive Committee of the S. D. Pharmaceutical Association met at Brookings, S. D. on October 28th to discuss problems that have arisen since the June meeting.

Wells EerNisse was selected by the members as local secretary and general chairman for the South Dakota Pharmaceutical Association convention to be held in Rapid City June 18, 19 and 20 of 1952.

A vote of thanks was extended by the society to the program committee consisting of **Miss Gwen V. Miller** and **Maurice Francis** for an unusual and successful program.

Marshall Davis, Vermillion, has received much publicity in the South Dakota newspapers regarding the trophy donations at the University and high schools over the state. The donations were started about 40 years ago by Marshall's father, Roy C. Davis and were continued by Marshall after he assumed management of the store when his father died. During the 40 year period over 200 trophies have been donated by the Davis family.

FAIR TRADE LEGISLATION

A new fair trade bill (H.R. 5767) has just been introduced by Congressman John A. McGuire. It has been referred to the House committee on Interstate and Foreign Commerce, and public meetings will be held when congress meets again in January. Now is the time to contact your representative and senator while they are home and call their attention to this bill and urge that they give it their best support. Also contact your fellow independent merchants, the hardware, appliance, grocery stores and other people that are interested in **Fair Play** which is just another way of saying **Fair Trade**. Even your farm friends can help you if they realize that it is not a price fixing law, but is intended to protect them from deceptive advertising on the part of unscrupulous merchants. The N.A.R.D. Journal and Bureau of Fair Trade will send out bulletins on this frequently. Read them carefully and pass on the information they contain. Congress will need your support at home to get this bill thru; do the best you can.

STOCK MARKET —

(Continued from Page 305)

security of the other half, for the following 50 years.

The only bona fide offers he had, goes the story, were bankers and he turned them down on the basis that their guarantee (burying the money in their vaults) was the weakest guarantee of all.

What he foresaw (inflation, the depreciating value of the dollar, and great taxes) has come to pass and while, even under these conditions, few feel the necessity of offering half for half, many men of means are exerting considerable thought and effort to at least trying to "stay even."

It is not difficult to see why this is true. Today the dollar as compared to 1939, is worth 53 cents, with 4 cents having been lost this past year.

Anyone who bought a savings bond in July of 1939 for \$75, for example, would, if the money had been reinvested, have a face value of \$102 today. But in actual buying power, the bond would be worth a little less than \$55!

(Continued on Page 316)

PRESIDENT'S PAGE

of the Pharmaceutical Division

A. O. Bittner

Continuing with the October message about some of our DOCTOR-DRUGGIST problems or gripes as termed by some, in Dr. Pankow's convention speech: Page 284 October Journal.

SELF MEDICATION

This is a common problem to the pharmacist and the physician alike. We are accused for indorsing advertised properties in having medicinal values just to sell the product and remuneration. We cannot deny this guilty undertaking in some manner. I might say from my own experience, that ten or more years ago this practice was more prevalent because the customer clientele gave more attention to these self medication preparations. The situation now has changed to the welfare of the druggist and physician. Most customers now ask to consult the pharmacist about a certain advertised product. The pharmacist of today makes an inquiry about the customers ailment they do not object, after a certain information is gained. We can give them advice and health information about products that are so superior to any patent self-medication preparations. We ask them about a correct diagnosis of their ailment, have they had one made? The answer usually is "No" Our next suggestion is: Why don't you see your physician, get a correct diagnosis of your problem and your physician will prescribe for you a correct treatment and in the end you will save not only many dollars of expense but also gain for yourself a satisfaction that you are receiving the correct treatment. Self medication is pretty well out and I believe that the pharmacist has a lot of credit coming for same. We pharmacists at times may be accused by a patient of making a diagnosis of an ailment, yes, the pharmacist said it may be so and so. Well in our conversation with the patient or customer his concluded remarks may be such to the physician, but dear doctor, when this patient comes to you, you will understand fully that this pharmacist had one directive in mind, and that is for you to make the diagnosis and prescribe the treatment.



THE DISPENSING PHYSICIAN AND THE COUNTER PRESCRIBING DRUGGIST

It is the truth, that the real gripes comes from these practices, just how they come about or originate are answers that either party may have some justification for. In a town or community where no drugstore is located, the practicing physician has no other choice and I know that these physicians would welcome to have a drugstore immensely. Then, there are many drugstores located in towns that have no practicing physician in their immediate community, their problem is intensified to refrain from a certain amount of what you may term counter-prescribing. Emergencies arise where the life of a patient apparently is at stake, the pharmacist is on the spot to administer some aid if a physician cannot be reached quickly on a telephone to prescribe. Most druggists have nearby physicians in other towns who gladly co-operate with them, so that counter prescribing practice does not have to be resorted to. Now, the willful intent of any druggist to counterprescribe, ignoring in every way to play ball with a physician is in violation of our code of ethics. That pharmacist undermines his profession and establishes a gripe that the physician justly is entitled to have. Likewise that dispensing physician who does not give his pharmacist a chance to compound and fill his prescriptions is establishing a gripe that the pharmacist is entitled to.

Fortunately these practices are on the way out. Successful physicians and successful pharmacists achieve only thru good teamwork and each adhering strictly to the code of ethics of their professions.

IN THE STATE OF SOUTH DAKOTA

I am going to make this statement: "I believe that the ethical practice of physicians and the ethical practice of the pharmacists is better than in any other state of the Union and I know that the aim of both professions are to keep it such.

AUXILIARY ACTIVITIES

Dear Auxiliary Members:

I am sure that by this time every district has received material from the State and National chairmen, and you are well along with the plans for your year. A wealth of material has been sent to you and there is an unlimited amount to be obtained on special subjects. Since this is true every group should be able to select that material which is sure to interest most of your membership. It is not expected that ALL this material is to be used, but only that which is applicable to your locality and will aid you in carrying out the aims of the Auxiliary.

Conference time is here again and on November 14 and 15 your president and president-elect, Mrs. V. V. Volin, are to be in Chicago for the 1951 Conference of State Presidents, President-elect, and National Committee Chairmen. The meeting is to be held in the La Salle Hotel and we are looking forward to being in attendance. It was a real privilege to be there last year, with representatives from 44 of the 48 states, listening to their successes and learning about every phase of Auxiliary work. This year your President is to appear on a panel discussion Thursday, November 15 on Health Days, so some time has to be spent on preparation. Mrs. Volin and I should be greatly benefitted and will be better able to help you with your problems.

I have sent letters to each district President, and a packet of material which I am sure many of you can use. I would be very glad to hear from the districts and want you to write me if you feel I can be of service to you. I know that I am expressing the wishes of every state officer in making this statement too. There is another item which I failed to call to your attention, but I feel is deserving of study and assistance, and that is THE SOUTH DAKOTA MENTAL HEALTH ASSOCIATION. Some fine material can be secured by writing them at their office at 712 6 St. Brookings.

A letter and questionnaire has gone out to the State Chairmen for information on just what has been accomplished so far in their departments. Distances prohibit our getting together very often to discuss these matters and this seems, to me, to be one way of finding out how far we have traveled.

I have just received the very fine yearbook of the Seventh District Woman's Auxiliary and appreciate their sending it to me. It is very compact and contains time and place of meetings, objects, officers, members of standing committees, hostesses by months and a complete list of their membership with telephone numbers. Many thanks to the Sioux Falls group!

The Third District Medical Auxiliary is the first to send in a complete list of their membership with street addresses. Hats Off to Them. If this is not done in your district, Presidents, please see that your secretary does this at once, for a complete mailing list is badly needed in order that your NEWS-LETTER be sure to reach you.

By the time you read this, Mrs. Volin and I will be home from the Conference, more enthused than ever over the great possibilities of the Auxiliary and the work it can do. The theme "WORKING TOGETHER FOR HEALTH," is a challenging one, and the opportunity for developing it, is unlimited. Let us in South Dakota contribute our share by:

1. increasing our membership
2. meet our quota of one subscription per member to "Today's Health."
3. increase the number of subscribers to the Bulletin.
4. plan interesting and enlightening programs by using material available thru your chairmen.
5. take part, collectively and individually, in health work on a local, state, and national level.

Mrs. Howard R. Wold, Pres.

The Third District Medical Auxiliary met in Flandreau, October 2. A dinner, with the doctors of the district, was enjoyed at the Tea Room of the Flandreau Indian School, after which the business meeting was held in the parlor of the school hospital. Mrs. Don Scheller presided and reports of committees were given. Dues were collected and a complete mailing list of members was made up for Mrs. Reding, editor of the NEWSLETTER.

The Madison members were in charge of the program for the evening and they discussed "The American Cancer Society and What It Is Doing In South Dakota For South Dakotans." This proved to be very interesting. A greater appreciation of their efforts resulted from the discussion.

It was decided that a discussion of some topic was to be held at each meeting, the choice being made at the previous meeting.

Three prospective members were welcomed and the Third District is off to a good start.

Mrs. Walter Patt,
Public Relations Chairman

* * * * *

Three prospective doctors and two prospective Auxiliary members have moved into the Third District during the summer months. They are:

1. David born to Dr. and Mrs. Don Scheller, Arlington.
2. Steven born to Dr. and Mrs. Mac B. Benjamin, Flandreau.
3. Richard born to Dr. and Mrs. Dean Austin, Brookings.
4. Barbara born to Dr. and Mrs. Robert B. Henry, Brookings.
5. Kathi Ann born to Dr. and Mrs. Berton Kolp, Volga.

Public Relation Chairmen:

Each district public relations chairman should have at least one news item from his district for the December Newsletter. Send these to Mrs. A. P. Reding, Marion, S. Dak.

* * * * *

The Third Medical Auxiliary has decided to gather supplies for Medical and Surgical Relief Inc. Each member is to bring some of the light-weight desired articles to the December meeting and a box will be shipped.

* * * * *

STOCK MARKET —

(Continued from Page 313)

The same would be true, of course, to holders of any type of high grade municipal,

rail or industrial bond or preferred stock, none of which have wide percentage movements one way or the other and all of which have been, in the past, dependable havens for investment funds.

This is no longer true today. To the contrary, bonds or any other normally stable investment media should be approached with more care than the more volatile media like common stocks.

In fact, common stocks today offer the man with excess capital probably one of the best ways of "staying even" with the inflationary trend that there is.

Anyone wishing to try to "stay even" via the stock market must still face two problems — the timing of the purchase and sale and the selection of the stock.

In the past, buying and selling of stocks has been known as "speculating" and although this term has been in ill-repute for years, it has never been more important that it be considered as a working method of capital conservation than at the present time.

There was a time when those who wished to invest conservatively with the idea of keeping the original capital intact and being satisfied with a normal return could do so satisfactorily.

That was before inflation. Now, any fund that is not continually increased in direct proportion to the diminishing value of the dollar is actually being decreased . . . being slowly but surely washed away by the tides of inflation.

One of the best ways to guard against this is to "speculate" in good common stocks and that means buying at the proper time and selling at the proper time. It does not mean gambling.

It does mean concentrated effort and study on when and what to buy and when to sell — either alone or, if time is limited, in conjunction with a professional consultant.

What will be the final result of our inflationary trend is not known: undoubtedly everyone will eventually lose heavily.

But those who will get the most pleasure from the "ride" will be those who will guard against going backward economically during the period by availing themselves of the opportunities for capital appreciation such as that available in the stock market.

Serum Protein Abnormalities Observed in Orthopedic Patients

Robert E. Van Demark, M.D.

During the past few decades a definite trend has developed in orthopedic practice away from strict anatomical form to emphasis on physiological function. For example, the presence of a spondylolisthesis means little in itself, for we now know that five per cent of the population will show this condition on roentgenographic examination and that strenuous activity may cause no symptoms.⁴ Since the development of the condition can apparently not be prevented, little attention is usually given to it as long as the condition does not result in disturbed function and pain. Likewise, a child acutely ill with poliomyelitis may show early respiratory embarrassment. This is no longer considered only from the standpoint of muscle weakness, for weakened muscles can, and often do, provide satisfactory respiratory exchange if the almost invariably present pulmonary edema can be eliminated in these acute cases.

Actually in certain cases of acute poliomyelitis, depression of the serum proteins can be demonstrated, beginning within the first three days and continuing until the seventh day or longer. The osmotic pressure is accordingly diminished, in some cases beyond the critical level where edema occurs. Values as low as 2 grams/100 cc. have been reported.¹ Normally the total serum protein concentration is 6-8 grams per 100 cc., of which 3.6-5.6 is represented by albumen and 1.3-3.2 grams by globulin. The normal albumen-globulin ratio is 1.5-2.5:1. In poliomyelitis the amount of serum albumen lost seems to be directly proportional to the severity of the case clinically. It can be shown³ by animal experiments that a rapid drop in serum albumen of 0.5 gm/100 cc. of blood will cause pulmonary edema. This same mechanism may occur in poliomyelitis patients, in addition to the obvious factor of diminished osmotic pressure. Irradiated plasma is most useful in preventing and controlling this drop in serum protein in the acute poliomyelitis patient.¹

As soon as the condition of the patient permits, dietary protein replacement should be started.

In the aged who have suffered acute injuries, bed sores occur frequently and are almost invariably associated with a low serum protein. Fifty to two hundred grams of protein may be lost each day from a decubitus ulcer and healing may become impossible unless this loss is replaced by active therapy.⁵ The topical treatment of decubiti in protein deficient patients has in our experience been prolonged and discouraging, unless correction of the deficiency is carried out concomitantly. On becoming ambulatory, edema of the lower legs is often seen in these patients and more particularly in the lower extremity which has been injured. Usually a history of dietary deficiency or idiosyncrasy is obtainable. The average American diet contains somewhat more than one gram of protein per kilogram (2.2 lbs.) of body weight; in the average dietary this amounts to more than sixty grams of protein a day. In the aged the requirement is about ten grams less a day.

Paraplegic patients in the early stages show a marked negative nitrogen balance while the muscles undergo atrophy and the appetite is poor. A low serum protein may occur and this may be further diminished by the loss of plasma at points of trophic ulceration. The latter occur particularly at pressure points (bony prominences) when the position of the patient is not changed at frequent intervals. Correction of serum protein deficiency in paraplegics can usually be obtained by a high protein diet.⁶ Generally, therapy of serum protein deficiency through the gastro-intestinal tract is much more effective than by vein. Amino acid therapy with hydrolyzed proteins has become a popular supplement to the diet. Parenteral amino acid nutrition has its place in patients in whom the gastro-

(Continued on Page 339)

Eruptive Diseases of A Contagious Nature*

ARCHIBALD L. HOYNE, M.D. CHICAGO

During the past ten years the general decline of nearly all the acute infectious diseases has been little short of phenomenal. Many of the so-called common contagious diseases are unfamiliar to those who have but recently embarked on the practice of medicine. In my own locality smallpox is a rare curiosity, scarlet fever is seen infrequently and diphtheria seldom encountered. Erysipelas and puerperal sepsis also seem to have withdrawn into retirement. Even whooping cough, measles, chickenpox and mumps appear to be less prevalent than formerly. However the last three have by no means been conquered and it is interesting to note that they constitute triumvirate of virus diseases which as a group seem to be in the ascendancy.

The foregoing circumstances present a serious problem to the medical student of today and sometimes to the practicing physician. How can one be expected to recognize readily that which he has never seen? Because of existing circumstances the diagnosis is apt to be made on the basis of a history. The mother thinks the child was exposed to measles. But the eruption may actually be German measles, scarlet fever, smallpox or urticaria. Perhaps you will say "anyone can make a diagnosis of measles." That is a favorite comment with us in the contagious hospital. And then we may argue for fifteen or twenty minutes before making a decision. On a number of occasions even in years past measles patients have been sent to our smallpox hospital and I have also seen severe attacks of smallpox when a diagnosis of measles had been made.

Although scarlet fever generally has no rash on the face, there is a flush with circumoral pallor. But the eruption on trunk and extremities is of a finely papular type with a subcuticular flush which fades on pressure. The mucous membranes of the throat are injected and tonsils frequently present the characteristic appearance of an

acute follicular tonsillitis. In this connection it is well to remember that the same organisms which cause tonsillitis in one individual may produce scarlet fever in another. In a typical case of scarlet fever the heavily coated tongue with enlarged papillae projecting — the strawberry tongue is a valuable diagnostic sign. Also the clean red tongue with raised papillae — raspberry tongue — which is usually revealed after three days of the rash may be helpful in determining the duration of the illness.

One would not often be inclined to believe that a urticaria is very difficult to differentiate from measles. Nevertheless the father of a child once told me that his little girl had measles on an average of once a month. It was somewhat difficult to suppress a smile and the father said rather indignantly "well that's what the doctor told me." Of course I assured him that his doctor ought to know.

Now let us look at some characteristics which show typical rubeola eruptions. You will note the characteristic maculopapular lesions which predominate on the face. Usually the eruption is not as dark a red on the trunk as on the exposed parts. With measles lesions usually will be found bordering the lips.

Rubella or German measles has attracted a great deal of attention in recent years, following the Australian reports of its damaging effects in early pregnancy. Now many obstetricians are extremely worried in regard to the slightest rash that a woman may have during the first three months of gestation. It seems to be assumed that if German measles occurs in the first trimester, the unborn child is certain to develop a deformity. However I do not feel so sure that is true. Moreover, Fox, after making an extended survey in Milwaukee expressed the opinion that abnormalities attributed to German measles were no more frequent than the general average. More recently a similar conclusion has been professed by others. Nevertheless a heavy responsibility may be placed on the

* Presented at the Seventieth Annual Meeting of the South Dakota State Medical Association, Aberdeen, June 5, 1951.

one who is called upon to confirm or to establish a different diagnosis. If the patient has German measles, termination of the pregnancy is almost certain to receive consideration. Should the eruption not be typical of rubella it is well to remember that a rash may occur with mononucleosis.

Chickenpox is usually regarded as an insignificant disease. It may occur very early in infancy. In fact on several occasions we have seen the eruption eight days after birth when the mother had the same infection. In older children a serious complication sometimes takes place and requires prompt recognition. Within two or three days after the eruption becomes evident, one may be impressed with the fact that the patient is very ill and it will be found that appendicitis is present. This is not an extremely rare complication. Moreover perforation is always likely and unless there is an immediate diagnosis peritonitis may follow. Encephalitis is a less frequent complication and the outcome is usually favorable.

In adults chickenpox is chiefly of importance because of its confusion with smallpox. In reality no great difficulty should be encountered; as a rule, in such a differential diagnosis. Even if not familiar with smallpox it is merely necessary to decide whether the patient has chickenpox. Yet many of the errors that have occurred were attributed to a lack of experience with smallpox. Some of you may recall New York City's difficulties in 1947 which cost that municipality approximately one million dollars for a campaign of vaccination. All on account of a much delayed conclusion in making a diagnosis. If I remember correctly one of the reasons for indecision was because the patient gave no history of exposure to smallpox.

If one is familiar with the eruptive diseases, the diagnosis should never be made on history. A history can not change a smallpox eruption to chickenpox nor a scarlet fever rash to measles. Nevertheless a history should be of great value in the case of contagious disease: (1) for the purpose of confirming the visual diagnosis and more important still (2) to obtain as much information as possible in regard to the number and location of those who have been exposed.

At least one additional fact pertaining to chickenpox should be mentioned. This is the

relationship which it bears to herpes zoster. When an individual who has never had varicella is exposed to herpes zoster there is always a possibility that he may develop an eruption characteristic of chickenpox. Moreover the incubative period corresponds with the latter disease. Because of the foregoing fact it is advisable for susceptible persons to avoid contact with herpes zoster patients. Much more rarely infection is transmitted in a reverse order. It is a common experience to find that when herpes zoster occurs in an adult, the patient gives a history of never having had chickenpox. But strangely enough herpes zoster does not seem to be conveyed from one person to another. Notwithstanding the observations that have been made some dermatologists maintain that the viruses of the two diseases are not the same.

Kaposi's varicelliform eruption is another condition that may lead to confusion. The chief question likely to arise is as to whether the lesions should be classified as chickenpox. The disease has also been erroneously diagnosed as smallpox. The chief characteristic of the Kaposi outbreak is its limitation almost entirely to areas of the body where a chronic eczema or dermatitis has existed. The vesicles are so characteristic of varicella that a differential diagnosis often presents a real problem. However the cause of the eruption is the virus of herpes simplex.

Referring once again to the differential diagnosis of smallpox and chickenpox there is often a misconception about what to expect concerning the general state of the patient's illness. Except in malignant cases the average smallpox patient feels better after the eruption appears. The temperature may have declined abruptly to normal and perhaps the patient will leave his bed and return to work after 3 or 4 days absence. On the other hand the one with chickenpox will feel worse after the lesions come out and if there are many crops the fever may reach 103 degrees or higher. He is ill and he knows it.

Erysipelas is now so uncommon that its diagnosis seems to be troublesome. We find that herpes zoster a distinctly unilateral disease is often mistaken for it. Also contributing to errors are acne rosacea, lupus erythematosus, ethmoiditis, cavernous sinus thrombosis, sunburn and even leprosy. Occas-

ionally cellulitis without erysipelas may be difficult to determine. It is proper to assume that erysipelas does not occur without trauma no matter how slight.

There are other diseases of a contagious nature that can be diagnosed sometimes by the distribution and character of an eruption before the causative agent is established by the laboratory. Scarcely anyone would doubt his ability to recognize scabies, ringworm, pediculosis or impetigo. But a small percentage of physicians would know Rocky Mountain spotted fever, typhus, or typhoid fever merely by inspection of the patient. Nevertheless one experienced with those diseases would undoubtedly have little trouble.

My comments are not intended to belittle the value of laboratory procedures for diagnosis but to emphasize the importance of observation. Meningococcemia with or without meningitis is an outstanding example of what may be accomplished. Even to one whose experience with this disease is limited errors in diagnosis would not seem likely. But many a physician with an extensive practice seldom sees a case of meningococcic infection. On that account an early diagnosis may not be made and others are exposed to a communicable disease. In addition, the patient's life may be endangered because of improper treatment. Purpura, subacute bacterial endocarditis, Rock Mountain spotted fever, drug eruptions, chickenpox and smallpox have been diagnosed when the true condition was due to meningococcic infection. When there are petechiae or massive hemorrhages in the skin a mere diagnosis of "capillary fragility" is not acceptable. The simple procedure of puncturing one of the lesions and making a smear may be the means of revealing an organism. When petechiae are present in meningococcic infections the gram negative diplococcus is usually found in more than 50 per cent. Among 727 cases we obtained positive smears in 62. per cent of those that were examined.

When a patient has meningitis and petechiae are present in the skin or conjunctiva it nearly always means that the meningococcus accounts for the illness. Therefore the disease is transmissible and is the only form of meningitis which is classed as contagious. Patients with massive hemorrhages and in

shock are often found to have hemorrhages in the adrenal glands, the Waterhouse-Friedrichsen syndrome. Nevertheless adrenal hemorrhage is probably not always present in such clinical pictures because some of the patients recover.

Treatment of most acute infectious diseases is far more successful since the introduction of the sulfonamides and antibiotics than in the past. This holds true particularly for meningitis because the range of effectiveness of the newer drugs is not limited generally to a single organism. Consequently beneficial therapy is sometimes instituted before the etiology of the disease is definitely known. Usually the prescribing of a sulfonamide will be helpful while awaiting the bacterial diagnosis. Then an antibiotic may be indicated also. However there is sometimes danger in over-medication. Chloromycetin and penicillin when given in combination are said to be antagonistic. On the other hand a sulfonamide and penicillin are considered synergistic. Recently we have been using terramycin for meningococcic meningitis and it seems to me that this may prove to be the best of all the antibiotics. It is administered chiefly by the oral route but can be given intravenously when well diluted. None of our meningitis patients are treated intrathecally so any danger of irritation by that route does not need to be considered.

A further recent development in the therapy of eruptive disorders pertains to some of the skin diseases. It has been reported that such conditions as psoriasis, forms of contact dermatitis, exfoliative dermatitis and pemphigus respond well to adrenocortico hormones.

Scarcely a dozen years ago we seemed to be close to the pinnacle of therapeutic achievement when biologicals were the specific weapons against many diseases. However the field of usefulness for the latter seems to be progressively diminishing.

Perhaps eventually there will be but one or two drugs for all diseases. In the meantime a definite diagnosis should be established and haphazard medication avoided. Infectious diseases which are characterized by eruptive conditions should be the first ones to receive early recognition. But that which we do not know we can scarcely be expected to recognize.

Porphyria Mixed - Case Report*

By T. J. Billion, Jr., M.D., Sioux Falls, S. Dak.

I'm going to try to cover a large amount of material in a brief amount of space. I have reviewed the literature on porphyria and have condensed it to the best of my ability. This condition as you realize is very rare and as a usual rule very few people practicing medicine have occasion to ever see a case of it in their life, and therefore have an equally rare occasion to look it up. I happen to be particularly interested in porphyria because since I've been back here, I have seen three cases. Of the three cases, the first one was missed a country mile, and like everything that we miss, I think it makes a lasting impression. I think our pride is such that we lean over backwards to avoid a recurrence.

Porphyria is of three types. The first type is congenital, also called light sensitive or photosensitive type. The second type is the intermittent acute form and the third type is a mixed type which is a mixture of congenital and intermittent acute form. The congenital light sensitive is the rarest as far as incidence is concerned. Up until 1947, there have been only six cases listed in this country, or have been written up and it is twice as common in males as it is in females. The intermittent and mixed types are much more common. However, they are fairly uncommon but are frequently overlooked due to their close mimicry of various other pathological states. Eighteen cases have been studied from 1939 to 1947 at the University of Minnesota where Dr. Cecil Watson is one of the outstanding authorities in the world and probably the outstanding authority in this country on porphyria. This is just the reverse of the other. It is twice as common in females as it is in males. As to the etiology, initially the congenital type was said to be hereditary while the intermittent acute and the mixed types were thought to be acquired. However, it is felt by all authorities both in this country and in Sweden, where most of the work is being

done, that they were hereditary, one being a recessive and the other being a dominant according to the Mendelian Law. In the **congenital or light-sensitive type**, the pathology is limited to the skin and teeth. Skin lesions limit to exposed surfaces head, nose, ears, face and arms. They start as vesicles of bullous lesions which become secondarily infected and form disfiguration due to scar formation. Teeth are red or reddish-brown. In the **intermittent acute form**; the pathology is limited to the nervous system and the muscles. The muscles atrophy and contract due to the production of flaccid paralysis. Peripheral nerves are involved and show evidence of neuritis. **Symptoms and signs**; photosensitive or the congenital type. First signs are usually small vesicles of bulla on exposed surfaces after exposure to light. Later scarring and disfiguration with loss of portions of nose, ears and fingers. Masculization especially pseudism in certain females. Now this, with exceptions of a few, cases have occurred in the first ten years of life. There are very few cases that have occurred later and in the literature there are about 33 cases reported and only three of these have been reported after the age of twenty. The latest one in life being thirty. **The intermittent acute form, the symptoms**; you may have are varied and they simulate any disease of the nervous system or abdomen. This has been a bugaboo to surgeons in certain cases and many of these cases, in fact most of them give a history of being operated on innumerable times, and also give the impression to most physicians that they are neurotics and have received that diagnosis. They have peripheral neuritis, flaccid paralysis of the extremities, bulbo palsy, hysteria, neuro circulatory asthenia, gall stone colic, renal colic, appendicitis, bowel obstruction, lead poisoning, acute glomerulonephritis, hyper-thyroidism, Addison's disease, unexplainable abdominal pain. The symptoms are usually limited to the nervous system or abdomen. **The nervous system**; it involves the central peripheral or automatic nervous system. The patient

* Presented at the McKennan Hospital Annual Staff Clinic Meeting, Nov. 29, 1951, Sioux Falls, South Dakota.

suffers undue nervousness for years, neuro asthenia, manic depressive symptoms or any psychosis, well defined psychosis, delirium, coma, grand or petit mal epilepsy, any one of the cranial nerves may be involved resulting in the optic atrophy, external lacular muscle paralysis, dysphagia, persistent attack of cardia, hoarseness, flexion paralysis of any or all 4 extremities or only weakness of extremities, periphra neuritis often seen with paralysis or evidence of external pain similar to that seen in diabetes. Pain is persistent and severe and frequently worse at night. **The abdominal symptoms:** Pain usually colicky in type and severe. It may be localized or generalized, often shoots down into the right thigh or leg. It's also been known to be seen in the left thigh and in the pain sometimes starting around the umbilical area shooting into the chest and into the back. Abdominal distension may or may not be present. Abdominal muscle spasm and rebound tendon is usually absent. Marked constipation is usually present. **Diagnoses in congenital type:** Urine is red when passed due to the presence of large amounts of uroporphyrin and this type of uroporphyrin can be determined with a stereoscope. In the intermittent type urine may be red when passed or it may be colorless. If allowed to stand in the direct sunlight several hours it will turn reddish brown. This is due to the fact that porphyrin melanogen, the precursor of uroporphyrin is a predominate pigment in the acute intermittent type that may have reduced to uroporphyrin by direct sunlight. Ehlick-Uhlenhuth's test will do the same thing on fresh urine. **Prognoses:** Congenital type live for years, dying from nonocurrent connections at one time or another. The Prognosis for intermittent acute type and also for the mixed type, 80% die within 5 years of the first symptoms repairable to the nervous system. In cases with no nervous symptoms and no involvement of the nervous system and only abdominal symptoms, the prognosis is much better and unless they develop nervous symptoms later, many of these people go on and live 4 score and 10. **The treatment:** congenital type protect from the sun, intermittent type demerol for pain, no barbiturates as soon as they feel they may in time precipitate or initiate an attack. It is now felt by most that they will. The barbiturates will precipitate attacks and intensify them.

The case I wish to report is that of a 25 year old male who is an accountant by profession. He gives the family history of a father who is 56 years of age and who the past two years has been known to have pernicious anemia. The mother on the other hand is 54 years of age and all her life she has been considered a neurotic. The patient when he first came to me told me that his mother had many of the symptoms that he had. I think that is the thing that started me thinking of this condition. The other thing was the fact that this individual (although my initial impression of him was that here comes another crock), actually impressed me with his sincerity. He impressed me as being an individual who did not enjoy being sick and who was very anxious to attain good health. There were the 2 things that made me think of this condition. The mother also proved to be hoprosferia. We made studies on her urine later. The family came initially from Lincoln, Nebr. The mother had all kinds of surgery done on her, a hysterectomy 30 years ago, an appendectomy at that time, and her gall bladder was removed. In fact everything that could be removed was removed and she still got no better. All her life she said she suffered from a skin disease which was described as scarring. It was a vesicular and bullous type. Getting back to the patient, he has no history of allergy although he says that all his life he's had blisters on his feet and that weren't trichophytosis. His father has apparently had them also. The patient had always enjoyed quite good health except for about the 3 summers when he was sick for 2 weeks with an upset stomach, as he described it, constipation and slight fever. He was in the army and while in the army in 1945 he felt pretty good. On one occasion he developed a severe fever during the evening. He didn't have any way of measuring it and felt better soon after. I initially saw him on the 10th of November 1949. He stated that 1½ years ago he awakened with a temperature of 103 which dropped to 94. He was in the hospital at Lincoln. Temperature dropped to 94 in three hours and he felt a feeling like a big lead ball in the lower right and left quadrants of his stomach. He felt extremely weak and markedly malaise and an anaraxia. The skin be-

(Continued on Page 340)

PRESIDENT'S PAGE

D. A. Gregory, M.D.

DECEMBER MESSAGE



The South Dakota Division of the American Cancer Society has initiated a new androgen service to the cancer patient. This service can be obtained by writing to them at Box 865, Watertown, South Dakota or telephoning Watertown 3476. Androgens have had considerable use in alleviating the distress of cancer patients and the society is to be commended for this addition to its other services in the fight against cancer. The medical profession should remember that every doctors office should be a cancer detection center.

No case of cancer can be discovered early, at its curable stage, unless it is looked for. I know this quite well.

The Secretary-Treasurer of the Aberdeen (1st) District Medical Society has sent me a schedule of the meeting for the entire year of 1951-52 ending May, 7th, 1952. This is an excellent plan giving the dates of the meetings, the speakers and the subjects discussed. This plan might be a good one for all the districts to follow.

I was very happy to attend the meeting of the Sioux Falls District on November 5th, and listen to a good talk on "Trends in Cardiology" by Dr. Olga Hanson. When I was secretary-treasurer of that District an attendance of fifty was exceptional. Now nearly a hundred attended and I enjoyed seeing the few old friends and many new ones. Especially pleasing was the meeting with the sons of old friends following the pathway laid out by their parents. Ours is a wonderful profession and the practice of medicine is the most fascinating profession in this world. No wonder the Greeks had Apollo the son of Zeus in their Pantheon of Gods. He was the God of Healing. Aesculapius was the son of Apollo. Hippocrates of Cos was famous as the founder of bedside teaching. The Hippocratic Oath according to Garrison was probably an ancient temple oath for priests of healing. So we have a high beginning to our profession and we should endeavor to maintain our work on high level. When it becomes state controlled it will be low indeed.

The District Societies will soon elect officers and recommend councilors. The selection of delegates and councilors is very important. They are the legislative body. Please select delegates and alternates who will attend and present the will of the District they represent. Let them know if you want changes made. If you do not have representatives present how can the House of Delegates and the Council know what the Districts want done. Your officers are executives.

Christmas will soon be here and then, alas! January, 1st and your final return by January, 15th to the Collector of Internal Revenue.

EDITORIAL PAGE

EARL WARREN AND SOCIALIZED MEDICINE

While we do not believe in commenting on partisan politics in our JOURNAL, we do feel that the members of the Medical and Pharmaceutical associations should know where the various candidates for public office stand on such subjects as socialized medicine. That is the reason for carrying the text of a letter from AMA president, John W. Cline, M.D., which follows:

"As you undoubtedly know, Governor Warren has been defeated repeatedly in attempts to secure the enactment of a program of Socialized Medicine in the State of California, but he now makes it clear that he believes such a program should encompass all the American people. It is significant that he made this statement only a few days before announcing his candidacy for President.

You will note that Governor Warren, in common with President Truman and Federal Security Administrator Oscar Ewing, repudiates the term "socialized medicine," while warmly embracing the substance. That has become accepted practice among those who seek a politically-dominated medical system, however, and no one should be misled by it.

Governor Warren, in his most recent statements, as in the past, has completely ignored the tremendous strides made by Voluntary Health Insurance in providing prepaid medical care for the American people. This is consistent with his position throughout the long fight in California on this issue, for he has always either ignored or belittled the progress of the Voluntary systems, despite the fact that there are now more Californians enrolled in Voluntary Health Insurance Plans than Warren promised to provide for under his scheme of Compulsory Health Insurance. Even coverage for catastrophic illness, to which Mr. Warren refers in his CBS statement, now is provided by California Physicians Service in his own State, but the Governor, for

reasons best known to himself, refuses to admit that anyone other than politicians can provide the people with adequate prepaid medical care.

On the issue of Compulsory Health Insurance, Governor Warren is in the Truman-Ewing camp just as surely as if he were formally enrolled in it, which, incidentally, President Truman has indicated he should be."

MEDICAL CLERKSHIPS

The old time preceptorship has come into vogue once more. In 1947, it was decided that South Dakota's medical students needed a down to earth view of the practice of medicine. It was also suspected that if the student were given first hand knowledge of the rewards of general practice, it might counteract the impressions made by much publicized disadvantages of the life of the family doctor.

Since 1947 approximately 115 students have spent a month's clerkship at the end of the sophomore year working with a doctor or small group of doctors. Since the doctors are responsible for the board and room of the student, this has often meant that the student has shared in the home life of the preceptor as well as participating in his office and hospital duties.

Each student is required to send to the medical school a detailed weekly report of his activities, and to write up one comprehensive case study each week. The reports must be read and approved by the preceptor before they are submitted. At the end of the clerkship, the student is required to write a criticism of the month's work, and the doctor is asked to evaluate the student as to intelligence, tact, enthusiasm, and adaptability. The chief criticism on the part of the student has been that he has not been permitted to do enough active work.

It is gratifying to see that South Dakota is taking definite steps toward interesting her young men and women in a return to rural and small town practice. It is to be hoped that the University will soon be able to have a full time Professor of Internal Medicine

who will be able to supervise the clerkships more closely and suggest improvements for the mutual benefit of the doctor and the student.

REPORT OF DELEGATE TO A. M. A. 1951 ANNUAL SESSION

The one hundredth annual session of the American Medical Association was held in Atlantic City, New Jersey, June 11-15, 1951. The total registration was about 28,500 persons and included approximately 12,250 physicians.

The scientific program and exhibits were judged to be outstanding in comparison with past meetings and were a beehive of activity.

The House of Delegates again had a very busy session. 200 of the 201 delegates in the house were present. This indicates the seriousness with which each delegate regards his assignment.

Dr. Allan O. Whipple of New York received the distinguished service award of the American Medical Association. His outstanding contributions in the field of operative surgery are too well known to require comment. He was victorious over Major General Harry G. Armstrong, surgeon-general of the United States Air Force, in a close ballot.

Dr. Louis H. Bauer, Hempstead, New York, was named president-elect. Dr. Bauer has served for many years on the board of trustees of the American Medical Association and has been its chairman during the past year.

Dr. John W. Cline, San Francisco, California, assumed the presidency of the American Medical Association. He gave an inspiring address which was broadcast throughout the nation over the ABC and Mutual Radio Networks.

In the Board of Trustees, Dr. Walter B. Martin of Norfolk, Virginia, was re-elected. Dr. David B. Allman, Atlantic City, New Jersey, was elected to fill the unexpired term of Dr. Bauer. The board selected Dr. Dwight H. Murray as its new chairman to succeed Dr. Bauer.

Dr. Oscar B. Hunter, Washington, D. C., was elected vice-president. Other officers were re-elected as follows:

Treasurer: Dr. J. J. Moore, Chicago, Illinois
Speaker of the House: Dr. F. F. Borzell, Philadelphia, Penn.
Vice Speaker: Dr. James R. Reuling, Bay-

side, New York

Secretary: Dr. George F. Lull, Chicago, Illinois

Dr. Elmer Henderson, retiring president and chairman of the American Medical Association Coordinating Committee, spoke to the House on the program of the National Education Campaign. It was the recommendation of Whitaker and Baxter, the committee, and the board of trustees that the campaign be terminated in December, 1951. The House of Delegates believed that the work should be continued in a modified way. The final decision was the employment of Clem Whitaker and Leone Baxter on a half-time basis. Dr. Henderson agreed to continue as chairman of the coordinating committee.

Many other resolutions were considered and acted upon. A full record of the work of the House is published in the Journal, which has come to the desk of each member.

The 1951 Clinical Session was held in Los Angeles, California, on December 3-6. The next annual session will be in Chicago, Illinois, in 1952.

Respectfully submitted,
H. Russell Brown, M.D.
Watertown, South Dakota

TEN RULES FOR SUCCESSFUL INVESTING IN COMMON STOCKS

There are innumerable rules to follow when buying and selling common stocks. Here are 10 of the most important.

1. It is more important to know **when** than it is to know **what** to buy and sell. 80% of investment success depends on the timing of the purchase and sale; 20% on what is bought or sold. Like on so many of the rules, most investors get these percentages in reverse. They spend practically all their time on individual stocks and little on the one important factor — the direction of the primary trend. The market moves like a great sweeping tide; when this tide is up, all stocks will advance; when it is down, all stocks will decline, with very few exceptions. Thus the great importance is knowing when to buy or sell, rather than **what**.

2. Cut losses short and let profits run. This is the one inviolable rule in stock investing. If the trend turns against you after you have made a purchase, sell and take your loss quickly. If the trend continues with you

after making a purchase, **do not sell** until the main trend does turn down no matter how huge your profits because they will get bigger. Like rule No. 1, most investors do this in reverse. They are too quick to take small profits and they are prone to let losses run until they become disastrous.

3. Never "marry" a stock. Today's blue chip may be tomorrow's yellow one. For example, canal and toll bridge stocks were once gilt-edged, as were also street railways; now, all are speculative dodos. Ten years from now, some of today's blue chips will be in the same category.

4. Don't worry about day-by-day fluctuations in the market. These daily fluctuations are of importance **only** as they serve to make up the monthly or yearly pattern. Watch your stocks daily as a matter of interest if you wish, but do not base your decision to buy or sell on a day's movement.

5. Don't keep your money employed all the time. In a bear market, money is better off in the bank or in the vault. It doesn't have to be "working" all the time for you; sometimes it is "working" more when it is idle.

6. Don't worry about the past. Yesterday's prices mean nothing. Don't be afraid to buy just because a stock that was 18 yesterday is 20 today. Today is another day and if it is time to buy, that is what you should do if the stock is 18, 20 or even 30. Conversely, just because a stock was 20 yesterday, it may not be a good buy today at 18 for tomorrow it may be 10. Concentrate on the major trend of the market and not on yesterday's individual prices.

7. Don't expect to buy at the bottom and sell at the top. And don't expect anyone else to help you do this. If anyone could do this, he would have had all the money in the world long ago. Figure your results on a percentage basis. If your dividends plus appreciation equal 15% per year, you should be happy. Where else could you do so well?

8. Diversify. Don't have all your funds in 1 stock or 1 industry. For the average investor, 5 to 8 stocks in as many industries makes an excellent portfolio. Less than that, denies you diversification; more, leads to confusion.

9. Speculate rather than invest. Speculating means buying stocks in a bull market and selling them in a bear market. It means attempting to increase capital by astute buying and selling. It does not mean gambling. Investing too often means buying stock and holding it forever with dividend return the sole objective. This is always dangerous, as outlined in point 3 above, and in an inflationary economy where \$1,000 today is worth \$750 tomorrow, it is outright foolishness. Capital should be constantly increased in our present economy; this can best be done through speculation and not investing.

10. Buy and sell "at the market"; stay away from margins. When it is time to buy or sell, tell your broker to do so "at the market." Fortunes have been lost by trying to scalp the last eighth of a point. Fortunes have also been lost by margin operation. While conservative today (only 25% margins are allowed now), it is still best to buy stocks outright. Borrowing money at the bank on real estate or on any other collateral to buy stocks is buying on margin. If you buy on margin, you are usually buying too much.

UNITED CEREBRAL PALSY

Early surgery is an important aid to some children who have been affected with Cerebral Palsy and more than 300 who would have gone through life with the condition are now living a normal life, it was reported by a round-table conference at the Second Annual Symposium on Cerebral Palsy of the United Cerebral Palsy Associations held here.

This important announcement was made at the conference by Dr. Donald Matson, of Harvard Medical School, who said that the early detection of blood clots on the surface of the brain and their removal by surgical procedures had produced health-giving results in the 300 children.

Another important advance in trying to find the injuries that produce Cerebral Palsy, came in the announcement by a physician from Johns Hopkins Hospital, to the effect that a survey is being conducted there to determine "what happens to a baby at the time of difficult delivery."

Discovery of these "delivery accidents" may lead in the future to the prevention of such injuries.

(Continued on Page 340)

This is



Vol. 4 No. 12
DECEMBER
1951

YOUR MEDICAL ASSOCIATION

PUBLISHED MONTHLY BY THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION

T. J. BILLION, SR. M.D., RECEIVES FIFTY YEAR AWARD AT McKENNAN



Photo by Herb Qualset—Argus-Leader

L. to R. L. J. Pankow, M.D.; F. D. Gillick, M.D.; T. J. Billion, Sr., M.D.

Dr. T. J. Billion, Sr., Sioux Falls, became the thirteenth member of the South Dakota State Medical Association to be awarded the Fifty-Year Club Pin. Presentation was made in a surprise ceremony at McKennan Hospital during a noon luncheon at the day-long McKennan staff clinic, November 14th.

L. J. Pankow, M.D., secretary-treasurer of the Association made the award presentation.

Dr. Billion graduated from Creighton University Medical School and began his practice in Sioux Falls in May of 1901. He has special-

ized in internal medicine and now practices in the Boyce-Greeley Building with his son Tom, Jr.

Present for the luncheon program was Dr. F. D. Gillick, dean of the Creighton University Medical School who gave the principal talk. Monsignor L. A. Hoch spoke on "The Spiritual Role of the Physician Toward His Patient."

Other speakers introduced by Dr. Pankow were Dr. W. E. Donahoe and Dr. Billion. Father Paul Carroll gave the invocation and benediction grace. The luncheon was provided and served by the Presentation Sisters.



Photo by Herb Qualset—Argus-Leader

L. to R. L. J. Pankow, M.D.; F. D. Gillick, M.D.; T. J. Billion, Sr., M.D.; T. Billion, Jr., M.D.; Mrs. T. J. Billion, Sr.; Mrs. T. Billion, Jr.; W. E. Donahoe, M.D.

NEWS NOTES

Nearly one hundred previously undetected diabetes cases (or suspects) were picked up in the Black Hills during National Diabetes Week when doctors provided testing services.

* * *

The family doctor was given a boost as the first line of defense against cancer at the annual meeting of the South Dakota division of the American Cancer Society. The statement was made by **Dr. Donald Breit**, member of the state cancer commission.

* * *

Dr. Paul Tschetter, Huron, was named chief of staff of St. John's Hospital in that city recently. **Drs. R. A. Buchanan** and **E. A. Hofer** were named vice-president and secretary-treasurer respectively.

* * *

Hill City has started a campaign to raise funds for a clinic in which they plan to house **Dr. Andreas Hesz** who is qualifying for licensure under the "DP Law."

* * *

Dr. Carl Mahler has located in Gregory in association with **Dr. J. E. Mannion**.

* * *

Dr. Eugene Weir has joined the staff of the Madison Clinic.

* * *

H. Russell Brown, M.D., South Dakota's AMA delegate just returned from the interim session in Los Angeles where AMA dues confusion was straightened out to some extent.

* * *

Dr. Marianne Wallis formerly of Mitchell and more re-

cently of Sioux Falls will practice radiology in Minot, North Dakota.

* * *

Two-hundred fifty two South Dakota physicians have placed their orders for the new "Heart Bulletin." Distribution of the Bulletin is made possible by the State Department of Health in cooperation with the S. D. State Medical Association and the Heart Association.

* * *

Dr. F. J. Clark has left Gregory to practice in Stewart, Nebraska.

* * *

Dean of the School of Medicine of Howard university, Washington, D. C., **Dr. Joseph L. Johnson**, arrived here Wednesday to visit the University of South Dakota School of Medicine. He stated he is particularly interested in the new medical and sciences building at the University.

Dr. Donald Slaughter, dean of the school, went over the plans of the building with Dr. Johnson and also took him through the unfinished building. Dr. Johnson reported that he is visiting medical schools throughout the mid-west and west to get ideas for the medical construction program at Howard university. He says that the favorable reports he had received concerning the University of South Dakota medical school building program and staff prompted him to include this state as the first stop in his itinerary. Howard university has a four-year medical school.

**PATRONIZE YOUR
ADVERTISERS!**

PIERRE DISTRICT HEARS CASE REPORTS

At the regular meeting of the Pierre District Medical Society, sixteen physicians heard case reports by three of their members and then went over the cases in person at the St. Mary's Hospital.

After the dry clinic the doctors and wives met at the Falcon Cafe for dinner.

Guests at the meeting were association president **D. A. Gregory, M.D.** and executive secretary, **J. C. Foster**.

HURON DISTRICT HAS HOUSEWARMING

The Huron District Medical Society were guests of **Dr. and Mrs. Buchanan** at a social get-together in their new home in Huron. A buffet dinner was served to thirty physicians and auxiliary members.

Dr. D. A. Gregory made his presidential visitation accompanied by Mrs. Gregory.

JOURNAL STAFF ATTENDS CONFERENCE

South Dakota Journal editor, **R. G. Mayer, M.D.**, Aberdeen, and two members of the Journal staff, **Mrs. Dorothy Weck** and **John C. Foster** attended a two day conference on State journal publication in Chicago November 12-13.

Presented at the meeting were discussions on makeup, writing, advertising etc. Panel discussions brought out individual problems of medical publications and tried to solve them by comments from other journal representatives.

MASONS HONOR HURLEY DOCTOR

Eighty Masons and Eastern Stars gathered at the Masonic Temple in Hurley to honor Dr. Edward Joyce for completion of fifty years as a member of the Masons. The meeting was held November 12.

Roland Almond, past master, was chairman of the meeting which included a prayer by Rev. Wendell Johnson, the reading of the doctor's Masonic record, and a presentation of the fifty-year service jewel.

YANKTON DISTRICT HEARS DORNBERGER

"Peptic Ulcer" was the subject of a paper presented at the regular meeting of the Yankton District Medical Society at Yankton State Hospital on December sixth. Dr. G. R. Dornberger of the Department of Medicine of Mayo Clinic presented the paper and then answered questions placed to him by the Society members.

The Ladies Auxiliary met with the doctors for dinner where they were guests of Dr. and Mrs. F. W. Haas, and then held a separate meeting afterwards.

HEART ASSOCIATION DISTRIBUTES BOOKS TO STATE TEACHERS

The South Dakota Heart Association has completed an initial distribution of pamphlets to school teachers in the State to aid them in handling students with heart disease.

The pamphlet entitled "What the Classroom Teacher

Should Know — And Do About Children With Heart Disease" describes the types of heart disease most often seen in children and advises them on the classroom handling. It also goes into the psychological and emotional needs of children with chronic illness and gives ideas on educational and vocational guidance.

The initial distribution went to over 1,800 teachers in the major city school systems. Further distribution will be made to school superintendents on request to the Heart Association office in Sioux Falls.

EXECUTIVE-SECRETARY ATTENDS DEFENSE MEETING

John C. Foster, Executive-secretary of the South Dakota State Medical Association attended a meeting on organization of medical care for civil defense in Chicago at the Palmer House on November 9-10.

The meeting was sponsored jointly by the AMA, American Hospital Association, Association of State Health Officers, and the Federal Civil Defense Administration.

AMA FELLOWSHIP DUES TO END THIS YEAR

The Board of Trustees of the American Medical Association, meeting in Chicago recently, decided to end Fellowship dues starting with the year 1952. Much confusion over membership and fellowship dues and their delinquent dates hurried the demise of the smaller amount.

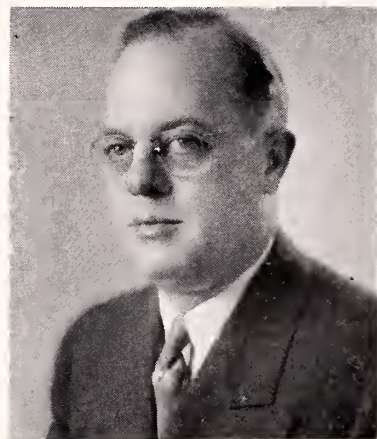
From January 1 on, the membership will be paying the annual dues of \$25.00 to support the many activities of the AMA.

MINNESOTA ANNUAL MEETING DATES SET

The Ninety-Ninth Annual Meeting of the Minnesota State Medical Association will be held in Minneapolis, Minnesota on May 26, 27 and 28, 1952.

All scientific and technical exhibits will be housed in the Minneapolis Municipal Auditorium.

H. R. BROWN, M.D. TO HEAD N. C. CONFERENCE



H. Russell Brown, M.D., Watertown, S. D., has been named president-elect of the North Central Medical Conference. Dr. Brown will become president after the 1952 meeting succeeding Dr. Floyd Rogers of Lincoln, Nebraska.

The North Central is a conference of representatives of the medical associations from Minnesota, North Dakota, Iowa, Nebraska, Wisconsin and South Dakota who gather annually in the Twin Cities to discuss problems of a med-

ical economic nature.

Last South Dakota president of the organization was Dr. William Duncan of Webster.

JOURNAL MEETING CLEARS PUBLICATION PROBLEMS

Problems of publishing state medical journals were highlighted at a meeting of state journal representatives in Chicago on November 12 and 13. At least two staff members of each state journal were in attendance to discuss makeup, editorial policy, and publishing costs. Attending from South Dakota were R. G. Mayer, M.D., Dorothy Weck, and John C. Foster.

In an analysis of costs and mechanics of operation, the SOUTH DAKOTA JOURNAL fared very well in comparison with most of the others. The average number of non-advertising compared to advertising pages was shown as a five to four ratio. South Dakota's showed a four to three which was not too much off the average.

In figuring the average printing cost per page, the South Dakota JOURNAL was the middle one on the scale at \$12.90 per page but was below the average of \$15.11. The JOURNAL showed the lowest cost for printing color and was one of the lowest in total postage costs.

The overall printing costs for the thirty eight journals represented ran from a low of \$6,000.00 to a high of \$55,000.00. The JOURNAL showed a cost in 1951 of \$10,129.63.

Editorially speaking, many

of the Journals are confronted with the problem of commenting on political issues, many hesitating to even mention such issues, while others feel it is their duty to express themselves on all issues of importance to their members and readers.

INDUSTRIAL HEALTH GROUP TO MEET

The 12th Annual Congress on Industrial Health will be held in Pittsburg, Pennsylvania, at the Hotel William Penn, January 18-19.

Prior to the opening of the Congress there will be a joint conference of the Council on Industrial Health of the AMA and the chairmen of the State committees on Industrial Health. Presentations of the joint meeting will take up experiences of medical groups in Industrial Health programs.

The actual congress sessions will discuss periodic health examinations, noise, eye health, women in industry and human relations in mental health.

SURPRISE DINNER GIVEN DR. F. S. HOWE

Dr. Frank S. Howe, Deadwood, was given a surprise testimonial dinner at the annual meeting of the Deadwood Chamber of Commerce.

A certificate of honor was presented which cited the many civic accomplishments of the doctor, and stressed his efforts in the establishment of the Black Hills Memorial Hospital trust fund.

A bronze plaque carrying an inscription will be presented at a later date.

AMERICAN COLLEGE OF GENERAL PRACTICE ADMITS NEW MEMBERS

The following doctors were admitted to membership by the Board of Directors of the American College of General Practice: J. C. Rodine, M.D., Aberdeen; C. E. Lowe, M.D., Mobridge; C. A. Johnson, M.D., Belle Fourche; R. Dean, M.D., Wessington Springs; C. D. Green, M.D., Canton; R. T. Maxwell, M.D., Clear Lake; and F. T. Younker, M.D., Sisseton.

Medical Public Relations Is Topic of Los Angeles Forum

Medical public relations was the subject of a two-day conference in Los Angeles just prior to the interim session of the American Medical Association.

Discussions on "What the People Think," "Cost Factor of Everyday Practice," "Medical Society Solutions to the Cost Problem," "The Physician's Responsibility as a Leader," "Joining Forces With Other Groups" and "Where Do We Go From Here" were held by repre-

sentatives of state and local medical societies. Much of the time was spent ironing out individual problems that PR personnel have run into.

Many of the larger state medical associations were represented by their public relations directors and PR committee chairman while others were represented by executive-secretaries charged with that work.

South Dakota was not represented at the conference.

PHARMACEUTICAL DIVISION

Charles F. Van De Walle, Editor

Professional Pharmacy*

Benj. A. Smith
Eli Lilly and Company

Mr. President, Officers, Members and Friends of the South Dakota Pharmaceutical Association:

I would not be satisfied if I didn't tell you that I thoroughly appreciate and enjoy the opportunity of being here with you this afternoon and appearing on your program, being a part of your program. I am awfully glad to be here with you. I certainly didn't accept Mr. Thomes' kind invitation to come out here with the thought of presenting an eulogy to the group, or trying to entertain the Association. I did not come here with the intention of campaigning for anything. I merely came here to present to you, to the best of my ability, a report — a factual report — on things of professional and economic interest within our profession. I certainly hope that I do not find myself in the position of a convention speaker when completing his talk turned to one of the audience, saying, "How did you like it?" His listener thought it over very briefly and said, "Well, you had some good ideas, and you had some new ideas." The speaker said, "Thank you very much, I am glad you liked my talk." The listener said, "Wait a minute, I haven't finished. Your good ideas weren't new and your new ideas weren't good."

I, personally, being a pharmacist, as practically all of you are, have a great deal of pride in the profession. I cannot help but feel that pharmacy offers wonderful opportunities. As a matter of fact, I have two young sons, ages three and eight, and while I should never attempt to influence their selection of a life's career except to insist that they specialize in something — I do not care whether it is medicine, law, carpentry,

or what it is, but I can think of nothing that would please me more than to have them on their own accord select pharmacy as their life's work. I sincerely feel that in pharmacy we have a wonderful opportunity to earn a very dignified living for ourselves and for our families; and we also have at the same time a very, very, unique opportunity to render health service to the people who are in need of help. I think we can all afford to be proud of our profession. It is true of course that many centuries ago our profession was very extremely inert. It was based almost completely on mysticism, but I think that everyone of you assembled here this afternoon will agree that it was from this early beginning of black magic in the profession of pharmacy that all of the modern sciences had their beginning. Think it over — all of the sciences, which are so important, so essential today, stemmed from the practice of pharmacy. I have no doubt at all that the greatest pace of advance in the profession has taken place in the last century. I think that four or five decades would cover it very nicely. For example, if we would turn back to say 1920, we would find that at that time when a physician prescribed treatment for a diabetic patient, that he most likely prescribed a huge dose of sodium bicarbonate. Of all things, sodium bicarbonate for diabetics, and why? To try and overcome the acidity that almost invariably accompanies that disease. It wasn't until 1922 when Banting discovered insulin that there was any treatment based on scientific fact available for the disease; and only then was insulin available throughout the markets of the world. After our own people, pharmacists, had devised a satisfactory method of isolation, standardization, and of purification, did we

* Presented at the S. D. Pharmaceutical Convention held at Watertown, S. D., 1951.

have the great host of therapeutic specifics which are so important. Medicine and pharmacy, we cannot deny, have traveled this real progress hand in hand, and always have been dependent upon the other. For no matter what new therapeutic agent is discovered, or by whom it is discovered, the pharmacist is invariably invited in at some time during its period of development to assist in putting it in its final form for distribution and consumption by the people who need it.

In spite of the great advance that has been made in our profession in recent years, we can't help but be just a little bit depressed at times when we hear some of the predictions that are made for the future of pharmacy. There are a lot of self appointed Peters in the profession today who agitate fear concerning the future of the practice of pharmacy. Not so very long ago, in looking through one of the national drug journals, I happened to notice within the very first few pages of that particular issue that there were more than a dozen serious threats to the profession, which we were given to understand would destroy the profession, or greatly impair it, if they were not corrected or altered within the very near future. Ladies and Gentlemen, I want you to know that I am not a pacifist in any way, shape, or form, but it is seldom, if ever, that I succumb to the cry of "Wolf, Wolf," and it is about some of these issues, some of these problems, some of these suggestions, that I would like to talk to you for a few minutes here this afternoon.

I have always felt that the problems, not only in pharmacy, but in any other profession or line of work, are as a rule problems of an internal nature. I think that too often it happens that the problems of a particular group are of an internal nature. They had their beginning, their development, and quite often their cumulation within that particular group, and very often it works out that that is the case. In pharmacy, I think a good example is the matter of the physician owned clinic pharmacy. I do not think that clinic pharmacies are such a serious problem here in the State of South Dakota at the moment, but there are some, and the physician owned clinic pharmacy is a very, very critical problem in other parts of the country. I say today, it is a problem of internal nature because you may have a community of four or five

thousand people, and in a town of that size it would not be unusual to have four or five retail pharmacies, each which might be doing a nice professional business of perhaps twenty-five or more prescriptions a day. In a community of that size there probably would also be eight or nine practicing physicians. One day the Doctors in that community will get together and decide to build a clinic, and of course they plan on installing in the clinic, a clinic pharmacy. Immediately, upon opening their doors for business, the retail pharmacists in that community that have been filling twenty-five or more prescriptions a day are cut out of the professional drug business. They are then lucky if they fill two or three prescriptions a week, and that, I don't think you will deny. This is a very serious problem, but I say it is a problem of an internal nature. We can trace it right back to pharmacy because is this not true that before the physicians can establish their clinic pharmacy, that one of our own people had to agree to go into that clinic and run that pharmacy for them. The solution of the problem is not quite as simple as that, nevertheless it points up to the fact that a lot of these things are of our own doing. When we think of them, and study them over, we are apt to become so chagrined that we feel like the boys who got into a poker game in the hospital. It seems there were three orderlies who had a little time to kill and one of them suggested that they have a little poker game. Having no cards, and being in the record office, they got some of the patient records out and used them. After dealing around, the first man said, "I have a pair of tonsillotomies." The second man said, "I have you beat brother, I have three appendectomies." The third man said, "I think I have both of you beat, I have five enemas, and that's a flush." Before we denounce the crime and attack it so viciously, I think we should sit back and have an objective view on some of these issues and problems.

We should attempt, at least, to ascertain just exactly what the issue is before we start writing our congressmen, etc. I recall as a student in pharmacy, I finished school just ten years ago, a group of us would get together and talk of our profession and what we hoped to do, what we wanted to do. Invariably, there would be one present in the

group who would have the audacity to predict that twenty-five to thirty years hence there would be no need for the dispensing retail pharmacists as we knew him then and as we appreciate him today; that he was being pushed from the scene of medical care by the great changes that were coming over the practice of medicine and medical techniques. Not so long ago when I was looking through one of the drug journals, I happened across an article that discussed this very subject. The author was speaking of the great number of changes that had come over the practice of medicine and how it affected pharmacy, and he ventured to say that when we have witnessed such changes within the comparatively brief space of forty years, who has the assurance to predict what, or if anything, will be left of pharmacy after another equally progressive lapse of forty years. I think you may be just a little bit surprised to learn that that article was written and published more than seventy-five years ago. It appeared in the July 1874 edition of the *American Journal of Pharmacy*. The same predictions are being made today, and the younger members of this group, I am sure, have discussed the very same issues. Despite that fact, pharmacy is on a more firm foundation now than it has ever been before in the history of the world; and nowhere in the U. S. is it more apparent than it is here in the state of South Dakota. From the floor of practically every pharmaceutical association meeting, just such as this, and within the pages of practically every pharmaceutical journal, we hear a lot of talk about the duplication of therapeutic agents which are on the market today. Of course, the duplication of products with which we are confronted now is a problem, particularly if we are interested in maintaining a level inventory, but while it is a problem it is my most sincere opinion that there is no pharmacist or no organized group of pharmacists, who, after due consideration, would of their own accord change the situation one bit. The reason I feel this way is because the multiplicity of products with which we are confronted now — so many new items coming out, is the manifestation of the medical program that we have spoken about previously. According to a very careful study made not so long ago, ninety percent of the items which comprise the bulk

of prescription sales in this country today, ninety percent were completely unknown in 1920. Fifty percent was completely unknown in 1940 and a third was totally unknown at the close of World War II in 1945. As far as the multiplicity of products are concerned, one item is released and then six other fellows have an identical item two or three weeks hence or less, that to me is a simple matter of free enterprise.

Free enterprise, and I think you will agree, is the very system of government under which we as individuals are privileged, if we so desire, to enter into fair and open competition with our own associates in pharmacy in the retail drug business. Free enterprise is the very system of government under which, with the good Lord's help, I think all of us are intent upon preserving. Perhaps one of the most serious problems confronting the health profession at this time is the matter of socialization, a great trend toward socialization. The socialization of medicine appears to be but a small facet of the huge over-all program, but I can't help but believe that the socialization of medicine is one of the most significant factors. The reason I feel that way is because shortly before his death in 1921, Nikoli Lenin uttered this statement, "Socialization of medicine is the keystone to the arch of the socialistic state." Is not then socialized medicine the opening wedge of the whole issue? Is not this socialized medicine the thing that would be the total socialization and eventually communization. I want you to know that I am not talking politics. I avoid any discussion of politics in a presentation of this sort. I know very well that you care not at all about my political beliefs or affiliations; and certainly your beliefs or affiliations are no business of mine, but I am speaking of us as an American people. It seems to me that we today have evolved into a race to see who can offer the most for nothing; and no matter what the issue is, if we tack the name social welfare on it, it is supposed to be good and we are supposed to be in favor of it.

If we are cranks enough to oppose it, we are advised not to take a negative attitude, but to have a positive attitude. That's not good. Consequently, for something that is bad, we offer something that is terrible. My friends, I cannot see anything wrong with a negative attitude. If we know that the situation or issue

at hand is not right, I cannot see anything wrong in saying "No" and taking the negative attitude. I would invite your memory to Exodus, Chapter XX, of the Holy Bible; and in the event you have forgotten, that is where the ten commandments appear. Not so long ago, I happened to be reading down the ten commandments and it occurred to me that of the ten, only one is written in the positive; and that is perhaps the most beautiful one. The one which begins "Thou shalt honor thy Father and thy Mother." All the others, the other nine, begin, "Thbu shalt not," so what is wrong with a negative attitude. Why is it necessary to offer something that is terrible in place of something that is bad.

We could go on and on discussing some of these issues, some of these problems, and as we did we would find a lot of them in direct opposition one to another. There has been a lot of discussion in recent months and years concerning the sale of drug store items in non-drug store outlets. It is very, very, difficult to understand the attitude that many of the profession have taken in regard to the Durham-Humphrey Bill. It seems to me, if there is any one thing which has granted the retail dispensing pharmacist a monopoly on the dispensing and sale of drugs it has been the prescription label. It is the one thing that has really effectively confined the sale of drug store products to the retail pharmacy; nevertheless, there are many opposed to the prescription legend. Loss of prescription legend on a great number of items would make it even easier for the non-drug outlet to sell these particular products because under the Durham-Humphrey Bill, the non legend items would carry on the label a complete description of the indications, warnings, cautions, side effects, and the dosage. The legend is the one thing that has retained the sale of these products in the retail pharmacy. That was covered very nicely by Mr. Sanford who preceded me on this platform. I enjoyed very much his address. I thought he had a very clear appreciation of the situation between the A.Ph.A. and the N.A.R.D.; and I thought he gave a very unbiased report. He mentioned the Secretary of the A.Ph.A., Dr. Fischalis. According to information I received yesterday — I have no confirmation — but I was given to understand that Dr. Fischelis has resigned and he will accept a position in

the University of Arkansas as Dean.

I always felt that the dispensing of drugs has been within the particular realm of the pharmacist; and I have always felt that knowledge of drugs and wisdom in dispensing has been the basis for the practice of pharmacy. Yet, if we would support the Durham Humphrey Bill, while it is true that prescription refilling must be straightened out, it will be done, and I think it can be done under existing legislation; if we support that bill we stand in a position of sacrificing to a government administrator hero control of our profession because we turn to the FDA and say "You tell us what we can do with it." It seems to me, while many organizations have gone on record as being in favor of the Durham Humphrey Bill, it is passing too much authority to the government; and Heavens knows they have too much now. To top things off, it passes the responsibility to the FDA, which you know is the baby of Oscar Ewing, the world's greatest proponent of socialized medicine. Would not the passage of this bill be another great step along the precipitous path of socialized medicine. I invite you to think it over before you start writing your congressmen. There is a very interesting little side light. Sometime ago, it hasn't been so many weeks ago, in addressing a State Convention, and before appearing on the program, I was listening to one of the men on the Resolutions Committee. I was interested in the attitude of the group on the Durham Humphrey Bill, so I asked him, "What is your opinion, or thinking, on the Durham Humphrey Bill?" His reply was, "Well, I don't know what it is, but I am in favor of it."

We could go on and on in discussing some of these things. If we would study the colorful history of the profession, one fact would stand out, and that is, that a lot of these issues that are presented as being entirely new have occurred and reoccurred with almost monotonous regularity. For example, the dispensing on the part of the physician. We think this is a serious issue today — and it is in some parts of the country — but dispensing on the part of the physician has been an issue since the 13th century AD when pharmacy was first separated from medicine.

Socialized medicine was an issue in France back in the 19th century. The Fair Trade practices were found in England about one

hundred fifty, or one hundred sixty years ago. It seems to me if there is any single answer to these problems, that the answer is simply partisan. I have yet to see a retail pharmacy who enjoyed a good professional business that was too much concerned with these issues. I have yet to see one that enjoyed a good professional business that wasn't in the position of making some money. One of the most gratifying things is that pharmacists in all parts of the country are becoming more and more aware of the fact, that the prescription department is where the money is made and consequently they are going after it — professional business. It is especially apparent since the close of World War II. I think this trend, this shift to the right, is mighty good for pharmacy because I most sincerely believe that the prescription business is pharmacy. I think it is a mistake to refer to the prescription department as one small back room in a retail drug store. The prescription department is the very pyramid of the entire drug industry. There are a lot of men and women in the profession who would take exception to that statement. It works out that fifteen percent of our retail pharmacies nationally are at this moment doing seventy-five percent, three fourths of all the professional business that is done in the country. Quite obviously there is great opportunity for expansion in professional business. One of the most gratifying things in the entire situation is that prescription business is growing steadily. It has grown very, very fast in the last few years. Last week we completed the new edition of the digest that will be printed and published about August. According to this new report prescription department sales continue to rise, and they are counted for 20.4% of total drug store sales as compared to 19% in 1949. Of a group of six hundred and sixty stores, the increase in sales amounted to .5% compared to a drop of about .5% in the 1,188 stores reporting in the entire digest. The digest, as you know, reflects the operational figures of a large number of stores. It is an average figure. I have never seen, or heard tell, of an average store. I don't think there is such a thing. Every retail pharmacy has things that are individual to that retail store — just as individual as is your own personality — but a report such as the digest, gives you a very

excellent yard stick in which to measure your particular operation. If your picture happens to fall below the average which is reported, then there certainly is something seriously wrong that needs immediate attention. If your picture happens to be superior to that which is reported as the average, that too may not mean too much when you consider the number of stores reporting — so there is always room for improvement. In our work on the digest, there is one thing we notice quite often and that is, that the stores that are doing a good professional business are the stores that are earning a good margin of profit. Certainly it is from the prescription department that we can expect our greatest monetary return, and it is from the prescription department alone that we can expect any professional recognition.

I do believe that by virtue of your attendance at this meeting, your support of the organization, that you are doing your best for pharmacy; that your activities are marked not alone on how much money can I make this week, this month, or this year, but at least in some small part with the thought of what can I do for the profession. I sincerely hope that is true. It is my humble opinion that that is one sure way to success and happiness in the profession.

RETIRED ALPENA DRUGGIST DIES AT WHEEL OF CAR NEAR MARION

Funeral services will be held in the school auditorium Thursday, November 22, for John Bentson, 71, retired Alpena druggist. Mr. Bentson suffered a fatal heart attack Saturday near Marion Junction while he and his wife and sister were en route to Marshalltown, Ia., and a two-car collision resulted.

Mrs. Bentson and her sister-in-law, Mrs. Clara Longsev of Silverton, Ore., were hospitalized in Sioux Falls as the result of the accident.

Mr. Bentson retired July 1, 1951, from the drug business, in which he had been active for 51 years, he had operated a drug store in Alpena for 21 years.

PHARMACEUTICAL GROUP MEETS

The Aberdeen District Pharmaceutical society opened its winter program of monthly

(Continued on Page 339)

PRESIDENT'S PAGE

of the Pharmaceutical Division

A. O. Bittner

DECEMBER MESSAGE

It was my first privilege to attend as a delegate the Annual Convention of the National Association of Retail Druggists. This convention was held in Minneapolis, October 14th thru 18. Many of the South Dakota druggists and their wives took a little time-off from their business activities and made use of this close-by opportunity to attend a National Convention and the Drug-Show, a part of it. All reports indicate that the attendance was one of the best.



PHYSICIANS AND DRUGGISTS ALIKE REGAIN RIGHTFUL PRACTICES.

Interpretations given by the Administration of the Food, Drug & Cosmetic Act involving practices of prescription giving to the patient since its enactment has caused a status of dissatisfaction among the physician and druggist. I need not review the many objections as both groups are well informed.

NOW, our N.A.R.D. has done a fine job again as always in the past, when the welfare **MEDICINE & PHARMACY** was at stake. It provided timely action, a quality of leadership and executive performance that resulted in a remedy which I am sure the physicians and pharmacists will underwrite as a **job well done**. The answer, "The **DURHAM-HUMPHREY BILL H.R. 3298**."

THIS BILL, has been passed by both houses and signed by the President and will become law, six months thereafter.

WHAT ARE THE ACCOMPLISHMENTS?

IT DEFINES BY LAW, FOR THE FIRST TIME, three broad general types of drugs which must be sold **only on prescription**. These are:

1. Habit-forming drugs (Narcotics and hypnotics).
2. Drugs which (a) because of their toxicity, (b) potentiality for harmful effect, (c) the method of their use, or (d) collateral measures necessary for their use, are not safe for use except under supervision of a practitioner licensed by law to administer them. This language is "intended to comprehend all drugs that in fact should be administered under medical supervision in order to insure their safe use."
3. Drug limited by an effective new drug application on file with the Food & Drug Administration to use under the supervision of a licensed practitioner. A classified list of drugs will be forthcoming which will catalogue the ones in categories (2) and (3), this will ease the problem for the druggist to classify them properly.

PRESCRIPTIONS MAY BE TELEPHONED.

Prescriptions may be either written or oral (telephoned). If they are given orally and are

for Rx-only drugs, they must be "reduced promptly to writing and filled by the pharmacist" The pharmacist is not required to record oral Rx's for over-counter drugs.

HOW TO REFILL RX-ONLY DRUGS.

Refilling is permitted only if authorized by the prescriber in the original prescription or orally at the time of refill. If orally, same must be reduced promptly to writing and filled by the pharmacist, just as an oral prescription must be recorded. F.D.A. is considering forms to be used by pharmacists for recording oral prescriptions.

DOCTORS AND DRUGGISTS, LET US QUICKLY FAMILIARIZE OURSELVES WITH THE ABOVE ESSENTIALS OF PROFESSIONAL PRACTICE.

As I see it, both professions are given added helps to safe-guard the public health in the use of these so many newer drugs and combinations thereof. The practicing physician must not relinquish his authority to have complete control of the prescription he gives to the patient, the time involved for the use of the medicament, the results obtained in therapy, this information must get back to the physician. We pharmacists must before refilling assure ourselves that the prescribing physician has this information and authorizes a refill or a continued medication. Laws and regulations effect a certain amount of control of practices, but between the physician and the pharmacist and the patient so many problems arise which only ethical principals of practice on the part of the physician and the pharmacist can solve. "THE FAITH THAT I HAVE IN MY DOCTOR AND MY PHARMACIST IS MY INSURANCE TO PRESERVE MY HEALTH AND LIFE" Says the patient or our customer. **How** is this faith built in this patient, (our customer?) Successful ethical practice on the part of the physician and the pharmacist is the answer.

A. O. Bittner, President

South Dakota Pharmaceutical Association

SPACE FOR SCIENTIFIC EXHIBITS WILL BE AVAILABLE TO MEMBERS OF THE MEDICAL ASSOCIATION AT THE ANNUAL MEETING IN MAY

FREE SAMPLE

DR. _____
ADDRESS _____
CITY _____ ZONE _____
STATE _____



AR-EX MULTIBASE

New Universal Ointment Vehicle Com-
patible with ALL Topical Medicaments

Prescribe ointments of cosmetic elegance — made with AR-EX Multi-
base. Applies readily, even to hairy areas, rinses off with plain
water. No screening action, making all medicaments available.



AR-EX COSMETICS, INC.

1036 W. VAN BUREN ST. CHICAGO 7, ILL.

AUXILIARY ACTIVITIES

Dear Auxiliary Members:

Mrs. Volin and I have just returned from Chicago and the Conference of state presidents and presidents-elect. Representatives from forty-five of the forty-eight states, national officers and committee chairmen were present and such enthusiasm! It is a real privilege to attend this session and how I wish more of our members could be present for two very full days of work, covering the main points of Auxiliary.

The theme was that chosen by Mrs. Harold Wahlquist, National President, as the slogan for the year, "WORKING TOGETHER FOR HEALTH." Panel discussions covering Organization, Finance, Nurse Recruitment, Today's Health, Health Days and Civil Defense, to name a few, were carried on by state presidents. Topics previously assigned were thoroughly and briefly covered so the over-all picture, made up of actual experiences of these presidents, was brought to us.

It was inspiring and educational to hear these women tell of writing personal letters inviting eligible doctor's wives to become members, one state raised their dues to include the price of "Today's Health" in every membership. North Dakota Auxiliary members put on rummage sales, benefit bridge parties, and bake sales, in the district, and raised funds to start two \$500 nursing scholarships in less than two years. Delaware members have actively taken over civil defense key positions, at the request of their state medical association. Several states reported the holding of Health Days, in their districts, with such success and cooperation from other organizations, that permanent health councils have resulted, and a solution to health programs on a local level have been worked out.

These are just a very few of the projects carried out by the Woman's Auxiliary in different parts of the country, and one could not help but feel that these doctor's wives were taking the lead, individually and as a

group in projects big and little, and helping to bring home to all the thought that "Health Is Everbody's Business." By their work and example they are proving that government intervention is not the solution and that there are means and ways in which the individual can and will solve his problem.

Dr. Ernest B. Howard, Assistant Secretary to the A.M.A. had high praise for the Woman's Auxiliary for the work they had done in the molding of public opinion, but warned that the election in 1952 offered a great challenge and we must be ready to meet it. The national emergency is being used as the excuse for pushing thru legislation, which will continue long after the emergency exists, and saddle the public with a tax burden and eventually socialize America. He asked each of the nearly 60,000 auxiliary members to be alert, informed, and ready to work to preserve the "American Way."

On Wednesday we heard Mr. Edward H. O'Connor, who was guest speaker at the state convention of the South Dakota Medical Association in Huron. He praised the Florida members for the big part they had in defeating Sen. Claude Pepper, and pointed out to us danger signals along the way on the legislative front. He showed us the unsound financial background for the Social Security program, and reminded us again that it was our job to make known the benefits of voluntary insurance plans.

The Honorable Walter Judd, M.D. of Minnesota, spoke to us on Thursday and brought home to us, in his very forceful manner, the thought that we are guardians of our form of government and that each of us must assume that responsibility. Our interest in those who represent us must begin at home in our own village, and continue to the highest office of the land, making sure that our choice is sound.

Mrs. Volin, Mrs. Reding, Regional Organization Chairman, and I came home enthused with the work of the Woman's Auxiliary and

its accomplishments on a national level, and more determined than ever that South Dakota is going to add its bit to the program.

Let us redouble our efforts to:

1. increase our membership to the Woman's Auxiliary.
2. increase our subscriptions to "Today's Health," the American Medical Association's public service to the laity.
3. help in the program for nurse recruitment.
4. volunteer our services in the civil defense program of our locality.
5. make every effort to become informed members.
6. take our places, individually and as a group, in community service.
7. take pride in our organization and learn of its aims and accomplishments thru the Bulletin.

Mrs. Howard R. Wold, Pres.

* * *

Your president was invited to attend a meeting of the Seventh District Medical Auxiliary, held in Sioux Falls, Nov. 6. It was a real pleasure to see the business like manner in which this group carried on their meeting and to hear the plans for the year's work. Place cards were envelopes for the payment of dues and it was encouraging to see the response. I was asked to bring them some ideas for program planning and I wish to thank Mrs. Stahman, their President, Mrs. Greenough, their Program chairman, and every member of the Seventh District Medical Auxiliary for a very pleasant evening.

* * *

District Secretaries . . .

Have you sent a complete list of all members, including honorary members, with street Addresses to Mrs. A. P. Reding, Marion, S. D.? This is urgently needed in order that a reliable mailing list for the Newsletter can be made up.

* * *

Public Relations Chairmen:

Are you sending news items of your district to Mrs. Reding for the Newsletter and to me for the Journal? These are YOUR publications, so let's hear from you.

PHARMACEUTICAL NEWS—

(Continued from Page 335)

meetings with a banquet in the Sherman

hotel.

Al Bittner reported on the Minneapolis convention of the National Association of Retail Druggists and Lloyd Kambestad told of his stay on the Madeira islands.

About 45 persons attended. The society includes all retail and wholesale druggists and sales personnel in the Aberdeen district.

Si Mark was in charge of the banquet. Willis Hodgson, vice-president, emceed the program and Eddie Olson had charge of singing and other entertainment. The next meeting will be in mid-November.

VAN DEMARK ARTICLE—

(Continued from Page 317)

intestinal route is of no avail.

In osteomyelitis cases with loss of large amounts of pus, the accompanying loss of serum protein may be excessive. When the losses are greater than one hundred and fifty grams a day, replacement may not be possible by the oral route alone.⁵

Hypoproteinemia has been reported in some cases of rickets.² The latter is rarely seen in our practise in an active phase, except for certain cases of cerebral palsy.

Hyperproteinemia is seen not infrequently in traumatic shock, where the increase of serum protein is always associated with hemoconcentration. In the experience of most clinicians the diagnostic and therapeutic value protein determinations in shock is not great as compared with simpler tests, such as the hematocrit, hemoglobin and red blood count. Hyperproteinemia also occurs in more than half the cases of multiple myeloma; again it has little diagnostic or therapeutic value in itself. In multiple myeloma the finding of Bence-Jones protein in the urine is of considerable diagnostic value.

REFERENCES

1. Bower, A. G., and Associates: A Concept of Poliomyelitis Based on Observation and Treatment of 6,000 Cases in a Four Year Period. Northwest Med. 49:103-107, Feb.: 187-190, March: 261-266, April: '50.
2. Cantarow, A. and Trumper, M.: Clinical Biochemistry. Philadelphia, W. B. Saunders, 1945.
3. Eaton, R. M.: Pulmonary Edema. J. Thoracic Surg. 16:668-694, Dec. 1947.
4. Friedman, M. M., Fischer, F. J., and Van Demark, R. E.: Lumbosacral Roentgenograms in 100 Soldiers; Control Study. Am. J. Roentgenology. 55:292-298, March, 1946.
5. Sodeman, W. A.: Pathologic Physiology: Mechanisms of Disease. Philadelphia, W. B. Saunders, 1950.
6. Street, D. M.: Treatment and Rehabilitation of the Paraplegic. Am. J. Surg. 80:722-726, November, 1950.

PORPHYRIA—MIXED—

(Continued from Page 322)

came yellow the next day. After 3 days he felt just about as good as he ever had felt and after one week he said he was positive that he was feeling as good as he ever did. Occasionally after that he would get a feeling of a lead ball in the lower quadrants and with an associated dull pain in the right flank. Also later, at the time that he got these attacks he would get a severe pain which would follow the sciatic nerve distribution extending, from his hip and going right down into his ankle. Two weeks previous to the time that I saw him he had an attack just like the initial attack with this lead ball feeling in his stomach and colicky pain shooting down into his leg and into his kidney area, with a temperature of 99. One time after that I saw him and he had again one of these attacks. That was February of 1950. In closing, this is particularly interesting because this man's urine was sent down to the University for an examination and it was initially found that he had a predominance of the coproporphyrin and only a trace of uroporphyrin. I thought initially that the diagnosis was incorrect. I talked to Dr. Watson about it and he said "no" that that was a case of mixed porphyria in his opinion and that he had seen cases with an excessive amount of coproporphyrin and only a trace or no uroporphyrin.

UNITED CEREBRAL PALSY—

(Continued from Page 326)

Dr. Klaus R. Unna, of the University of Illinois, told the opening meeting of the three-day conference of the promising discovery of new drugs to make life easier for the sufferer of Cerebral Palsy by helping them to relax.

Some of the researchers are working under grants from the United Cerebral Palsy Associations in its fight to help prevent the condition that affects an estimated 546,000 persons in the United States. Many other thousands, unknown to organized groups are also suffering from Cerebral Palsy.

Dr. Samuel Hicks, of Harvard Medical School told the meeting that experiments on animals has shown that the use of x-rays and some drugs have produced Cerebral Palsy in

the animals.

His study will show just what happens to animals when x-ray treatment and certain drugs are given. He has thus far determined that these injuries can occur up to and after the time of delivery of the animal.

This study, Dr. Hicks indicated, would show where x-ray and use of certain drugs might be contra-indicated.

Dr. Randolph Byers, also of Harvard, discussed a survey of certain individuals for a period of 20 years to show the life history of Cerebral Palsy, and just what happens to them.

Dr. Fred A. Mettler, of the College of Physicians and Surgeons, Columbia University, discussed the needs of the child with Cerebral Palsy and the necessity to educate the parents on what to expect in this problem.

Dr. Charles F. McKhann, Medical Director of United Cerebral Palsy Associations in summing up the round-table conference, held at the Philadelphia County Medical Society Building, stated it is the efforts of these researchers that hold out the promise of a better future for the Cerebral Palsy sufferer and his parents.

Other speakers on the opening-day program included Dr. Paul I. Yakovlev, Harvard University Medical School, Boston; Dr. George Anderson, Assistant Professor of Obstetrics, Johns Hopkins Medical School, Baltimore; Dr. James Hughes, Associate Professor of Pediatrics, University of Tennessee, Memphis and Dr. Waldo E. Nelson, Professor of Pediatrics, Temple University School of Medicine, Philadelphia.

**BELLE FOURCHE STARTS
NEW BLOOD BANK**

Fifty Belle Fourche residents answered a call for blood donors last month at John Burns Memorial Hospital to establish a new blood bank in South Dakota.

Thirty pints were taken at the first drawing. Plans call for two pints of each kind to be kept in stock at all times, the remainder to be stored at St. John's Hospital in Rapid City.

Dr. Wayne Gieb, Sister Jane Francis, and Mary June Peck of Rapid City handled the taking of blood donations.

The Belle Fourche blood bank is the thirteenth in the State.

Index to Volume IV

BY TITLE, SUBJECT AND AUTHOR

A

- Annual Meeting—1951 191-215
Auxiliary Roster—1951 290

B

- Baker, W. J., M.D.
Carcinoma of the Prostate
Gland 151
Bathine 301
Billion, T. J., Jr., M.D.
Porphyria Mixed—Case
Report 317
Bittner, A. O.
Pharmaceutical President's
Page 224, 288, 314, 336

C

- Carcinoma of the Prostate
Gland 151
Chemotherapy of Cancer 160
Choice of Kidney Incision 100
Committee on Trauma,
A.C.S. 80
Community Participation in
Psychiatric Nursing 261
Creedy, C. D., M.D.
Hematuria 263

E

- Editorials
Association Membership 250
Attendance at Medical
Meetings 116
Crime Pays In Many
Ways 221
Dangers of Federal
Subsidy 72
Earl Warren and Socialized
Medicine 324
Longevity—Ewing's Pride 304
Maternal Death Rate 46
New Insurance
Endorsements 83
Oscar Ewings Little
Helper 25
Quackery in South
Dakota 275
Review of State Legislation
Concerning the Medical
Profession—32nd
Biennial Session 83
"The Grass Grows From
the Ceiling" 25
Wages and Prices and
More Control 145
Early Diagnosis of Acute
Abdomen 269
Elkins, Earl C., M.D.
Treatment of Convalescent
Poliomyelitis 59
Eruptive Diseases of a
Contagious Nature 318

F

- Foster, John C., Executive
Secretary
Mid-Century White House
Conference on Children
and Youth 22

G

- Gjenvick, B. A., Rev., M.S.W.
Some Consideration of the
Use of Professional
Social Case Work by the
Physician Involving the
Welfare of Children 138
Greenfield, R. E., M.D.
Early Diagnosis of Acute
Abdomen 269
Gregory, D. A., M.D.
President's Page
..... 176, 189, 255, 272, 303, 323
Guthrie, R. H., M.D.
Survey of Yankton State
Hospital and Redfield
State Hospital 167

H

- Head Injuries 165
Hohf, R. P., M.D.
Chemotherapy of Cancer 160
Helpful Points in the
Diagnosis and Treatment
of Liver Disease 236
Helwig, F. C., M.D.
Pathology of New Growth
of the Thyroid Gland 109
Hematuria 263
Hospital Service vs Medical
Practice 18
Householder, R., M.D.
Severe Fractures About
the Ankle 39
Hoyne, A., M.D.
Eruptive Diseases of a
Contagious Nature 318

I

- Interprofessional Relations 282

K

- Klemme, R. M., M.D.
Head Injuries 165

L

- Larson, C. S., M.D.
Primary Carcinoma of the
Lung 11
Leinfelder, P. J., M.D.
The Diagnosis Significance
of Some Ocular
Complaint 43
Why Test Visual Fields 77
Livingston, Robert F., M.D.
Choice of Kidney Incision 100

M

- MacMillan, Katherine
Community Participation
in Psychiatric Nursing 261
Malignancies of the Spinal
Cord and Peripheral
Nerves 95
Masters, W. H., M.D.
The Rationale and Tech-
nique of Sex Hormone
Replacement in the Aged
Female and a Prelim-
inary Result Report 296

- Medical Costs as Applied
to Pharmaceuticals 311
Mickelson, W. D.
Modern Merchandising 256
Mid-Century White House
Conference on Children
and Youth 22
Minutes of Committee on
Medical School Affairs,
Medical Education and
Hospitals 276
Minutes of Council
Meeting 68, 276
Modern Merchandising 256
Moudry, F. W.
United Action and
Progress 31

N

- Newer Therapeutic
Agents 136, 183
Northway, W. H., M.D.
The Care of Poliomyelitis 105

O

- Ogborn, R., M.D.
Bathine 301

P

- Pankow, L. J., M.D.
Hospital Service vs. Med-
ical Practice 118
Interprofessional
Relations 282
President's Page
..... 24, 45, 71, 82, 115, 144
Parry, Edgar
Newer Therapeutic
Agents 136, 183
Pathology of New Growth
of the Thyroid Gland 109
Pharmaceutical President's
Page 224, 288, 314, 336
Porphyria Mixed—Case
Report
President's Page
..... 24, 45, 71, 82, 115, 144, 176,
..... 189, 255, 272, 303, 323
Primary Carcinoma of the
Lung 11
Professional Pharmacy 331
Pruitt, R. D., M.D.
The Care of the Cardiac
Patient Undergoing Sur-
gical Treatment 244
Putting the "Farm Assist"
in the Animal Health
Department 88

R

- Rehabilitation of the
Handicapped 103
Rehabilitation of the
Quadriceps 80
Report on the Financial and
Physical Layout of a
Drug Store 51
Reul, T. W., M.D.
Medical Costs as Applied
to Pharmaceuticals 311

Riggs, T. F., M.D. Rehabilitation of the Handicapped	103
Roster—Alphabetically	218
Roster—District—1951	216

S

Sachs, Ernest, M.D. Malignancies of the Spinal Cord and Peripheral Nerves	95
Serum Protein Abnormalities Observed in Orthopedic Patients	317
Severe Fractures About the Ankle	39
Smith, Claude L. Report on the Financial and Physical Layout of a Drug Store	51
Some Consideration on the Use of Professional Social Case Work by the Physician Involving the Welfare of Children	138
Spurbeck, G. F., M.D. The Ocular Mucous Membrane Syndrome of Erythema Multiforme Exudativum	157
Stauffer, M., M.D. Helpful Points in the Diagnosis and Treatment of Liver Disease	236
Stebbins, W. N. Putting the "Farm Assist" in the Animal Health Department	88
Stern, C. A., M.D. The Office Diagnosis and Treatment of Sterile Couple for the General Practitioner	131
Supplementary Report of Secretary-Treasurer	275
Survey of Yankton State Hospital and Redfield State Hospital	167

T

The Acute Abdomen	229
The Care of the Cardiac Patient Undergoing Surgical Treatment	244
The Care of Poliomyelitis	105
The Diagnostic Significance of Some Ocular Complaints	43
The Ocular Mucous Membrane Syndrome of Erythema Multi-forme Exadativum	157
The Office Diagnosis and Treatment of the Sterile Couple for the General Practitioner	131
The Rationale and Technique of Sex Hormone Replacement in the Aged Female and a Preliminary Result Report	296
Thorek, Phillip, M.D. The Acute Abdomen	229
Treatment of Acute Allergy Met in General Practice	1
Treatment of Convalescent Poliomyelitis	59

U

United Action and Progress	31
----------------------------------	----

V

Van Demark, Robert, M.D. Serum Protein Abnormalities Observed in Orthopedic Patients	317
--	-----

W

Why Test Visual Fields?	77
Wittich, Fred W., M.D. Treatment of Acute Allergy Met in General Practice	1



From where I sit by Joe Marsh

Easy Makes His "Cat" Tread Lightly

Driving home on Three Ponds Road yesterday, I was flagged down by Easy Roberts' boy Skeeter. "Take it slow," he advised. "Dad's crossing with our tractor, just beyond the bend."

Around the curve I saw why Skeeter stopped me. Easy had laid two rows of old truck tires across the road, and was driving his new "Cat" tractor over them!

"A little more trouble this way," Easy explains, "but it keeps those tracks from tearing up the asphalt when I cross over to our other fields. After all, the roads belong to all of us—and I guess I'd get mad if someone else chewed them up."

From where I sit, Easy is my kind of citizen. He doesn't just give democracy lip service—unlike certain other people who are always prescribing what "road" we should take. Whether it's practicing a profession, the choice of your favorite beverage, or the right to use the public highways, I figure it's up to all of us to protect every individual's "right of way."

Joe Marsh

